Submit Fee-for-Service Claims to Medical Assistance

Receive Timely and Accurate Payments for Covered Services

This chapter shows how to:

- Submit claims using any of the following methods:
  - Direct data entry into ProviderOne.
  - Process online batch submissions (837).
  - Paper.
- Submit Electronic and paper Back up Documentation on Individual Claims.
- Resolve Errors during a Claim Submission.
- Submit Commercial Insurance secondary claim.
- Saving a claim.
- Submit Medicare Crossover Claims.
- Check on the Progress of a claim.
- Submit claim Adjustments.
- Resubmit a Denied Claim.
- Void a Paid Claim.
- Creating a template claim.
- Submitting a template claim or a batch of template claims.

Why Is Correctly Billing Medical Assistance Important?

This chapter is designed to help providers submit claims correctly to reduce the need to resubmit claims. All the instruction up to this point will increase success in billing Medical Assistance and getting reimbursed in a timely manner.

When providers determine that the client is eligible for Medical Assistance, the service is covered, Medical Assistance is the primary payer, and any authorization requirements have been fulfilled (if required), providers may bill Medical Assistance after the service is rendered.

Disclaimer

A contract, known as the Core Provider Agreement, governs the relationship between the Agency and Medical Assistance providers. The Core Provider Agreement's terms and conditions incorporate federal laws, rules and regulations, state law, the Agency rules and regulations, and the Agency

program policies, numbered memoranda, and billing instructions, including this Guide. Providers must submit a claim in accordance with the Agency rules, policies, numbered memoranda, and billing instructions in effect at the time they provided the service.

The Agency does not assume responsibility for informing providers of national coding rules. Claims billed in conflict with national coding rules will be denied by the Agency. Please consult the appropriate coding resources.

The Key Steps

1. Determine Claim Submission Method
2. Determine if Claim Needs Backup
3. Submit New Claims and Backup via:
   a. Direct Data Entry into ProviderOne
   b. Direct Data Entry a Commercial Insurance Secondary Professional Claim
   c. Saving a Direct Data Entry Claim
   d. Online Batch Claims Submission
   e. Paper
4. Submit Medicare Cross-Over Claims
5. Inquire about the Status of a Claim
6. Adjust, Resubmit, or Void a Claim
7. Creating a Template Claim
8. Submitting a Template Claim or a Batch of Template Claims

Key Step
1

1. Determine Claim Submission Method

Why?

The Agency wants providers to receive timely payments. Providers usually base their claim submission method decision in part on the volume of claims billed and the level of technology they have available.

We encourage providers to submit claims electronically. Electronic claims typically process much faster than paper claims. Information on the claim will remain the same regardless of the billing method used.

How

Select one of the methods below:

- **Direct Data Entry of individual claims into ProviderOne** – ProviderOne enables providers to submit new claims, check claim status, submit adjustment claims, revive denied claims, and attach electronic backup documentation to claims. Updates to ProviderOne claim options enable providers to create and save template claims, create a claim from the template and also create batches of claims using saved templates.
- **Electronic Batch Claim – Self Submission**. Electronic claims are submitted to the Agency directly by the provider. Providers use a companion guide[1] to keep their software up to date. Electronic Batch submitters are required to pass testing with the Agency and have a Trading Partner Agreement (TPA)[2].
- **Electronic Batch Claim Submission – Billing Agent or Clearinghouse**. Electronic claims are submitted to the Agency through a Billing Agent or Clearinghouse**.** These companies use a companion guide to keep their software up to date. Electronic Batch submitters are required to pass testing with the Agency and have a Trading Partner Agreement (TPA).
- **Paper Claim Submission**
  - Institutional (i.e. hospitals, nursing homes, hospice, home health, kidney centers) claims are submitted on a UB-04 claim form.
  - Professional (e.g. physician) claims are submitted on a CMS-1500 claim form (version 08/05)
  - Dental claims are submitted on a 2006 ADA form.
  - Medicare Crossover (e.g. Professional or Institutional) claims are submitted on a UB-04 or CMS-1500 claim form (the same form used to bill Medicare).

Pitfalls

- **Submitting paper claims. Electronic claims process much faster than paper claims.**

[1] ProviderOne companion guides are located at http://www.hca.wa.gov/medicaid/hipaa/pages/index.aspx
[2] Trading Partner Agreements are located at http://www.hca.wa.gov/medicaid/hipaa/pages/index.aspx

Key Step
2

2. Determine if Claim Needs Backup

Why

Claims billed to the Agency may need backup documents if the client has:

- Commercial Private Insurance
- Medicare
- Medicare Advantage Plan

You must attach backup documentation to a paper or electronic claim when a specific type of service requires additional information. Examples of these back up documents include:

- Invoices for Acquisition Costs (AC)
- By Report (BR) services
- Operative Reports or other documents, if required or requested by the Agency

How

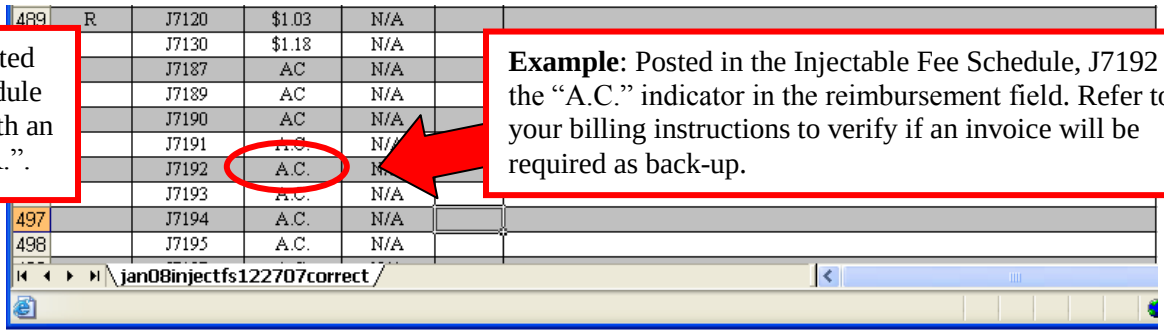
Explanations of Benefits (EOB) may be needed if there is a primary payer.

- If a provider is submitting an EOB with a claim, the information on the claim must match the line information billed to the primary payer as reflected on the EOB.

Documentation is needed for some services.

- Acquisition Cost (AC) and By Report (BR) services are listed in the fee schedules. Review Fee Schedules at http://www.hca.wa.gov/medicaid/rbrvs/pages/index.aspx .

Some codes listed in the fee schedule are denoted with an "A.C." or "B.R.".



Example: Posted in the Injectable Fee Schedule, J7192 has the "A.C." indicator in the reimbursement field. Refer to your billing instructions to verify if an invoice will be required as back-up.

- **Drugs** with an **AC** indicator in the fee schedule with billed charges of $1,100.00 or greater, or **Supplies** with billed charges of $50.00 or greater, require a manufacturer's invoice in order to be paid. Attach a copy of the invoice to the claim and note the quantity given to the client in the *Comments* section of the claim form. It is not necessary to attach an invoice to the claim for procedure codes with an **AC** indicator in the fee

schedule for drugs with billed charges under $1,100.00, or supplies with billed charges under $50.00, unless requested by the Agency. Bill only **one** unit of service on the claim. See page 4 of the Physician-Related Services Billing Instructions for additional information.

- Services with a **BR** indicator in the fee schedule with billed charges of $1,100.00 or greater require a detailed report in order to be paid. The report describes the nature, extent, time, effort, and/or equipment necessary to deliver the service and must be attached to the claim. It is not necessary to attach a report to the claim for services with a **BR** indicator in the fee schedule with billed charges under $1,100.00 unless requested by the Agency. See page 4 of the Physician-Related Services Billing Instructions for additional information.

- The Agency may deny a claim and request an Operative Report to justify medical necessity for services.

Pitfalls

- **Failing to include required back up information with the claim. This will result in claim denial.**
- **Billing services that were not billed to the primary payer. This will cause the claim to be denied.**
- **Failing to check eligibility to determine if another payer exists.**

Key Step
3

3. Submit New Claims and Backup:

a. Direct Data Entry into ProviderOne
b. DDE - Commercial Insurance Secondary Professional Claim in ProviderOne
c. Saving a Direct Data Entry Claim
d. Online Batch Claims Submission
e. Paper

Why

- The Agency offers multiple free methods to submit claims for payment for services supplied to our clients. The Agency encourages providers to bill by some type of electronic method to optimize payment receipts and to improve resubmission turnaround time in case a claim is denied for a billing error. This section will cover the billing methods available in detail.

- It is important to submit claims within the timelines allowed to ensure payment.

Initial Claims [WAC 182-502-0150 (3) (4)]
Providers must submit their claims to Medical Assistance and have a transaction control number (TCN) assigned by ProviderOne within 365 days from any of the following:

- The date the service was furnish to the eligible client;
- The date a final fair hearing decision is entered that impacts the particular claim;
- The date a court orders the Agency to cover the services; or
- The date the Agency certifies a client eligible under delayed certification criteria.

The Agency may grant exceptions to the 365-day time limit for initial claims when billing delays are caused by either of the following:

- The Agency certification of a client for a retroactive period; or
- Providers prove to the Agency that there are extenuating circumstances.

Note: The Agency follows the National Correct Coding Initiative (NCCI) policy. The Centers for Medicare and Medicaid Services (CMS) created this policy to promote national correct coding methods. NCCI assists the Agency to control improper coding that may lead to inappropriate payment. The Agency bases coding policies on:

- The American Medical Association's (AMA) Current Procedural Terminology (CPT®) manual
- National and local policies and edits
- Coding guidelines developed by national professional societies
- The analysis and review of standard medical and surgical practices
- Review of current coding practices

How

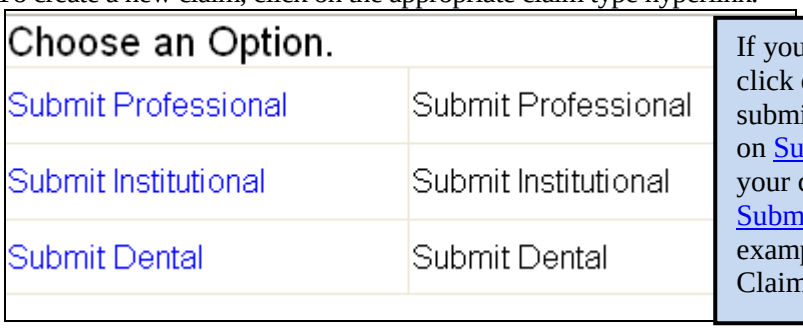
3a. Direct Data Entry (DDE) Into ProviderOne

- Log into ProviderOne and choose the **EXT Provider Claims Submitter** or **EXT Provider Super User** profile.

It is extremely important before preceding any farther into the claim submission process to **TURN OFF** the **POP UP BLOCKER** on the web browser. ProviderOne utilizes pop-up windows during the claim submission process and submitters will not see those if the pop up blocker is turned on.

- From the ProviderOne home page (Provider Portal), click on the "On Line Claims Entry" hyperlink.

To create a new claim, click on the appropriate claim type hyperlink.

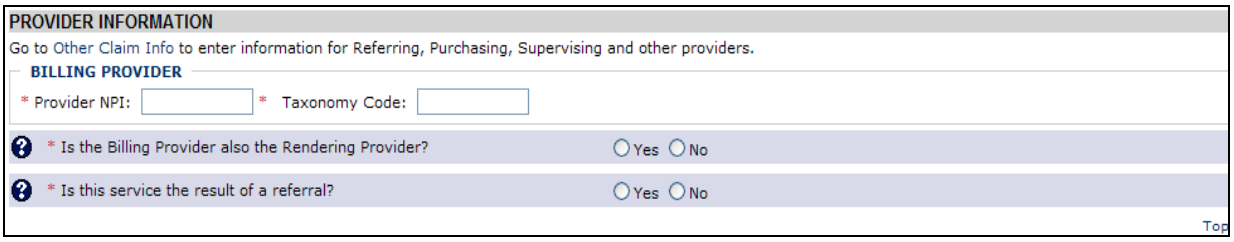


If you submit your claims on a UB-04 form click on Submit Institutional Claim. If you submit your claims on an ADA form, click on Submit Dental Claim. If you submit your claims on a CMS-1500 form, click on Submit Professional Claim. For this example we will use Submit Professional Claim.

Complete the data fields required and any additional information needed. If a provider has questions regarding billing policies, please refer to the appropriate billing instructions for the claim type. For convenience, there is a link to the billing instructions at the top of the DDE claim page.

Submitting a Professional Claim

Enter the billing provider's NPI number and taxonomy code. (See Memo 10-22) Depending on how the next two questions are answered, additional NPI numbers and taxonomy codes may have to be entered for those providers. For more information on taxonomy codes, please see Appendix L.

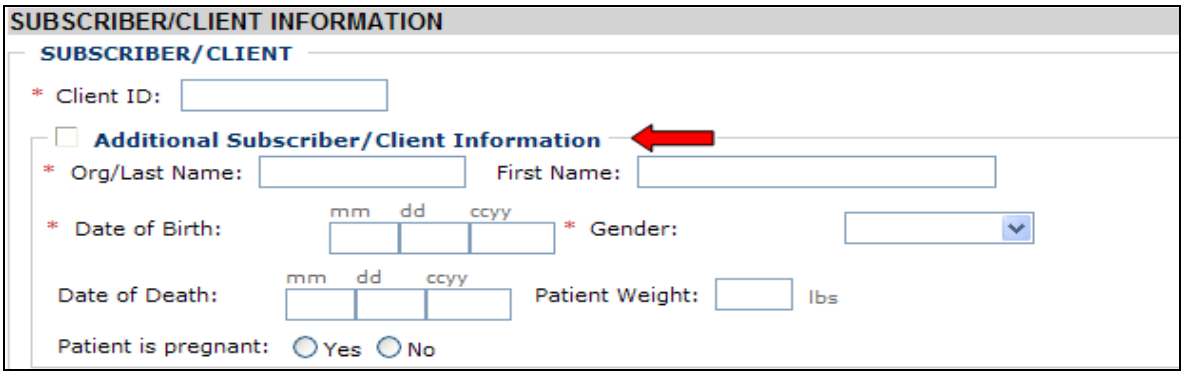


How do I answer the questions?

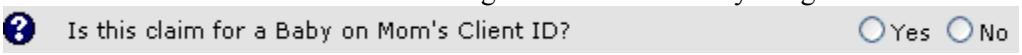
- For a solo practice office, the Billing Provider would also be the Rendering Provider.
- For a clinic or group practice, the Billing Provider would not be the Rendering Provider. Answer this question "**No**" and then fill in the NPI/Taxonomy for the provider that rendered the service at the clinic.
- If the service provided is the result of a referral from another Medicaid enrolled provider, answer "**Yes**" and enter that provider's NPI. A taxonomy code is not required for a referring provider.

Client information

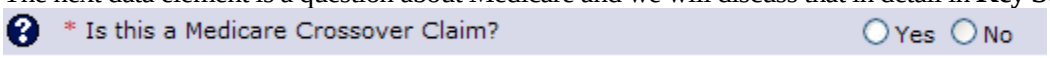
Enter the ProviderOne client ID (e.g. 123456789WA) and expand the box by clicking the red plus sign to enter the client's name, birthday, and gender. **Client's birthdate, last name, and gender are required on all claims.** While the first name is optional, if entered, the first name will also be printed on the provider's RA. When billing for a newborn claim using mom's ID, enter the baby's name, baby's birthdate, and the baby's gender in the boxes instead of mom's information.



Click "Yes" on the radio button if indicating the claim is for a baby using mom's ID.



The next data element is a question about Medicare and we will discuss that in detail in **Key Step 4** below.



If the claim requires authorization, click on the Prior Authorization expander and enter the authorization number.

Sometimes a claim note needs to be added to the claim so that it processes correctly. To add a note, click on the red plus sign to expand the note option, and then type in the note information keeping it short.

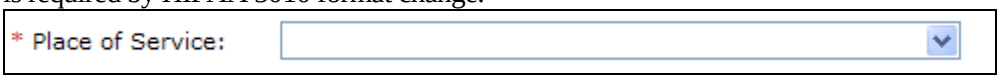
Some of the reasons to add a note or claim indicator are:

- "SCI=B" for baby on moms ID
- "SCI=I" for Involuntary Treatment Act (ITA)
- "SCI=V" for voluntary (psych) treatment
- "SCI=F" for Enteral Nutrition – Client not eligible for WIC
- Twin A, or Twin B; or Triplet A, Triplet B, or Triplet C if newborns on mom's ID
- "Sending Insurance EOB" if sending the primary insurance back-up

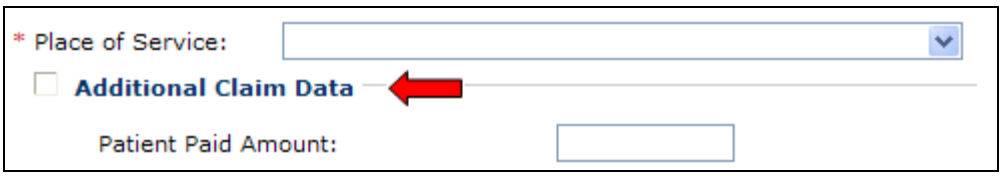
Answer the next question.

Use the "Patient Account No" field to enter any internal patient account numbers used. This information will be printed on the Remittance Advice.

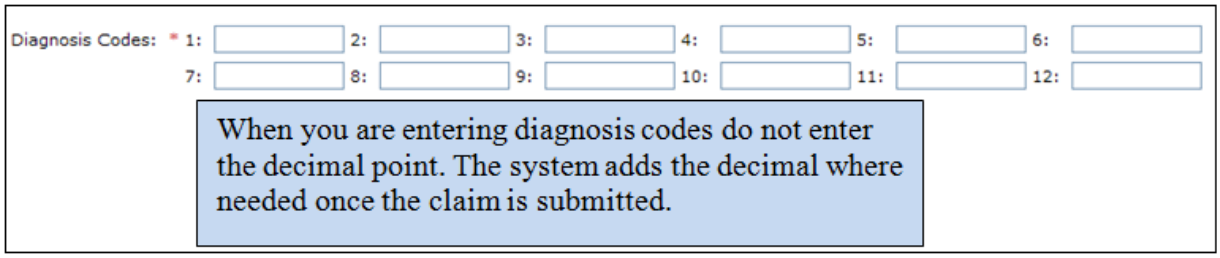
Enter the Place of Service code number using the drop down option. This location for the place of service code is required by HIPAA 5010 format change.



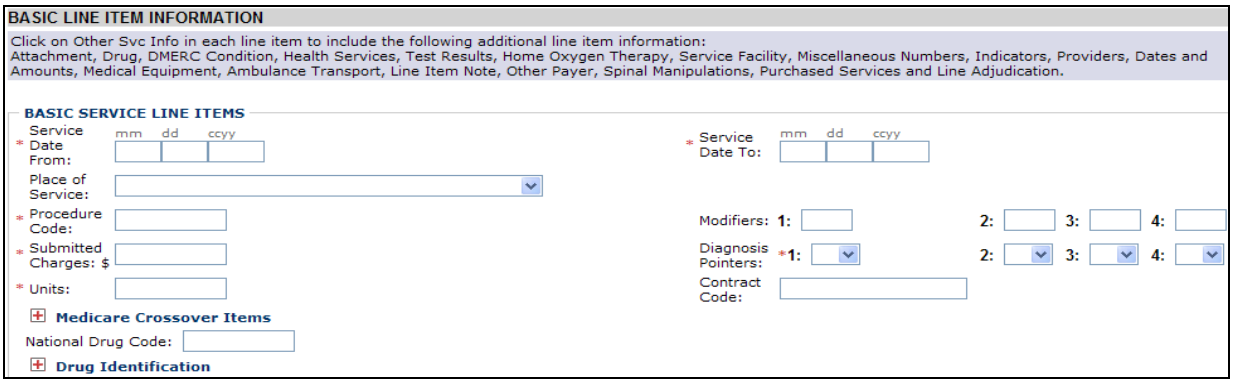
If a client has a spenddown and that spend down amount needs to be reported on the claim, expand the **Additional Claim Data** field and enter the spenddown amount in the "Patient Paid Amount" box.



Now enter the diagnosis codes. HIPAA allows up to 12 fields for diagnosis codes. Later a pointer is used to indicate which diagnosis code applies to the service line.



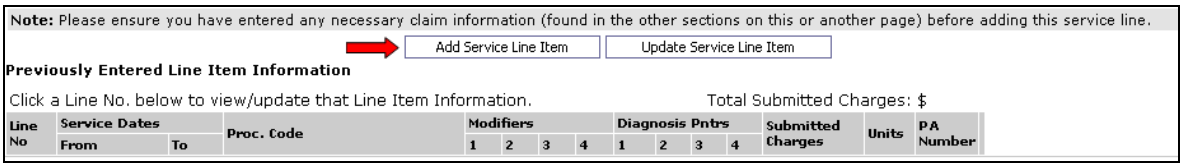
Next enter the basic line item information. Using the "tab" key can speed up filling out the claim form.



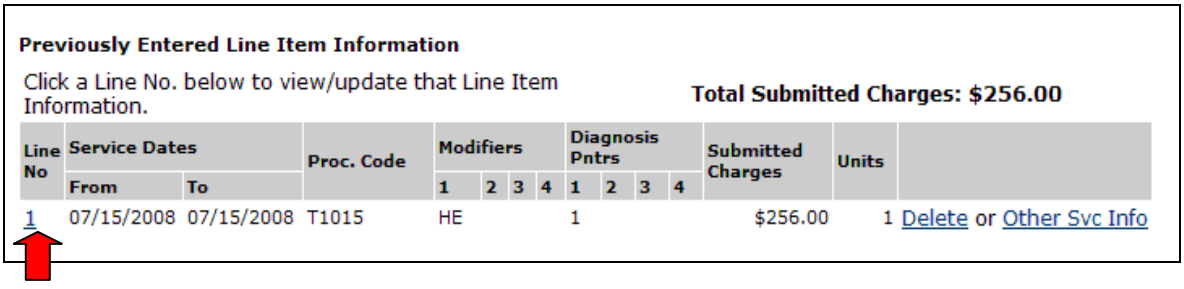
- Enter the "from" and "to" date of service. Enter date spans here for equipment rental, etc. then tab;
- Use the drop down option to indicate the place of service (optional, as the date of service has already been entered at claim level);
- Enter the procedure code being billed on this line, then tab;
- Enter the Modifier (s) if appropriate, then tab thru the other boxes;
- Enter the billed amount. (whole dollar amounts do not need a decimal point), then tab;
- Indicate using the diagnosis pointer number which diagnosis from above will be used on this line. It is possible to indicate multiple diagnosis for the line, or just tab thru;
- Enter the number of units to be billed. At least one unit must be indicated.

Enter a National Drug Code (NDC) only if you are billing a code that requires the NDC. If not required skip the box.
The expander here for Medicare Crossover Items will be discussed in **Key Step 4** below.

Then click on Add Service Line Item.



The entered line information will appear under the section named "Previously Entered Line Item Information". Make sure every line has the correct information and appears under this section before submitting the claim.



Need to edit that line due to a keying error or coding mistake?
Simply click on the line number of the line to correct; the system then repopulates the service line items boxes. Make the changes as necessary, and then push the Update Service Line Item button. The system will change the original coding line to the corrected information.

Quick Tip: Providers can use a "shortcut" when adding more lines to the claim. Use the edit feature of the system to quickly add more lines. Click on the line number to repopulate the service line items boxes. Now add the information for the next line by overwriting what is there, only changing what is different. Generally speaking, only a procedure code and the billed amount would change, or in some cases the codes are the same but the date of service would be changed. Once the information is updated as needed, click on the "**Add Service Line Item"** button to add the new line. Repeat this process to add line 3 and 4 etc.

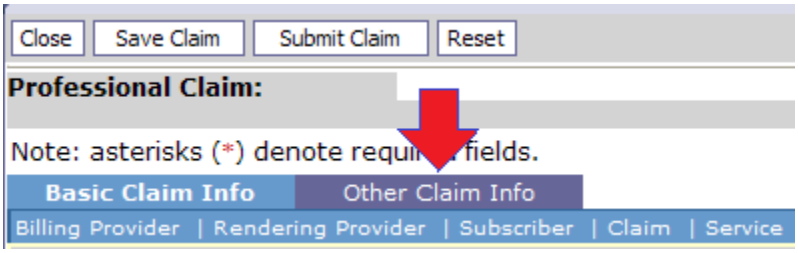
Continuous Hospital stay Information (only if applies)

Clients that are fee-for-service (FFS) when admitted to a hospital and then enrolled in an agency managed care organization (MCO) during the hospital stay, the entire stay for physician services is paid FFS until the client is discharged. Enter the initial hospitalization date in the appropriate field for your claim billing format.

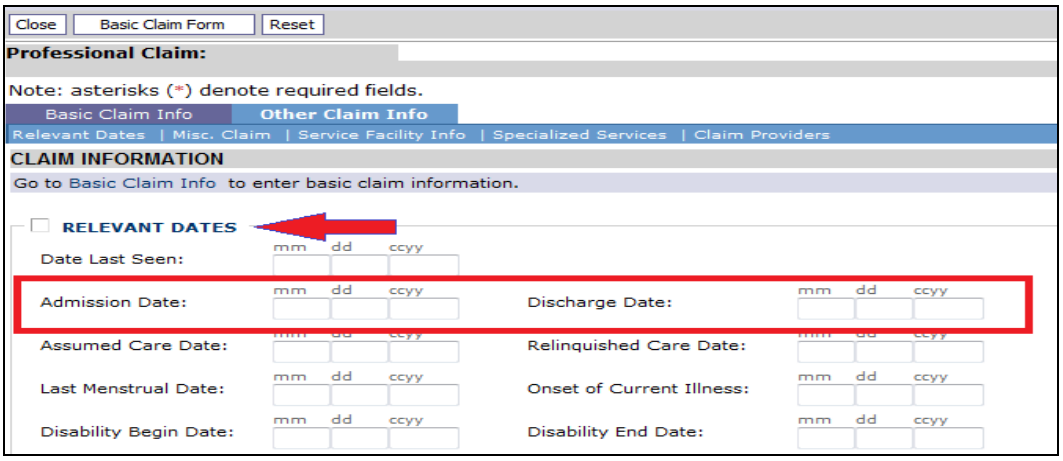
DDE

Fill out the claim form as normal and before submitting a claim for a continuous hospital stay enter the hospital admit date and discharge date per below instructions.

1) Click on the "**Other Claim Info**" tab at the top of the page.



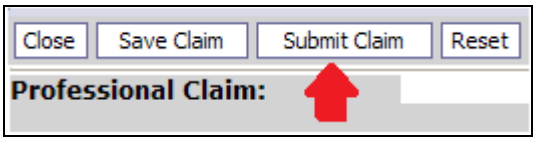
2) On the Other Claim Info page open the first expander "**Relevant Dates**".



3) Enter the Admit Date and Discharge Date for the hospital stay.

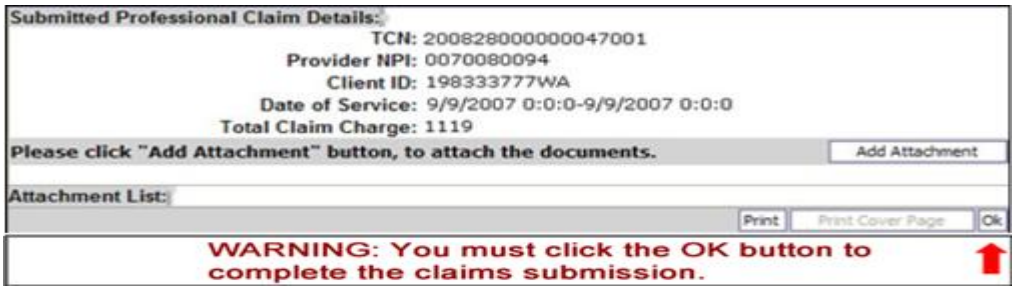
4) Click on the **Basic Claim Form** button at the top of the page to get back to the first page of the claim screen.

After entering all the claim information, click on "Submit Claim" button at the top of the screen.



The following pop up window message should appear:

If no back-up is being submitted, click "cancel" button and the following window appears:



Clicking **OK** submits the claim to ProviderOne and returns to a blank claim screen ready to enter another claim.

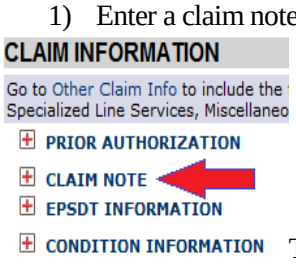
Submitting Backup Documentation to a DDE Claim

ProviderOne allows the biller to submit backup two ways to the DDE claim:

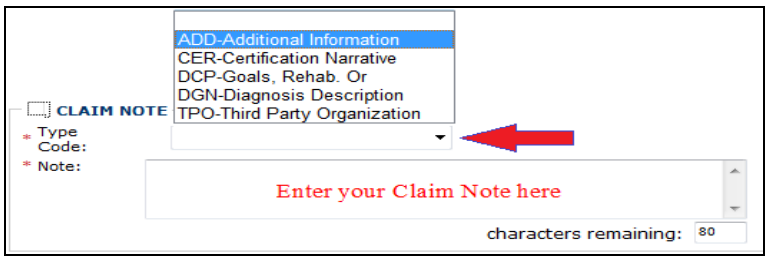
- Add an electronic attachment file
- Submit paper backup with a cover sheet

If backup will be submitted with a DDE claim be sure to add a claim note indicating what is being sent with the claim so claims processing staff will look for the backup.

1) Enter a claim note by:

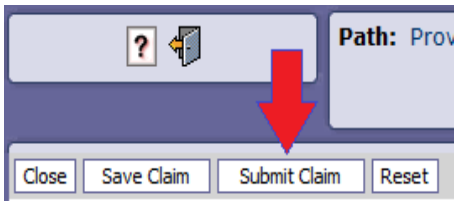


Then →

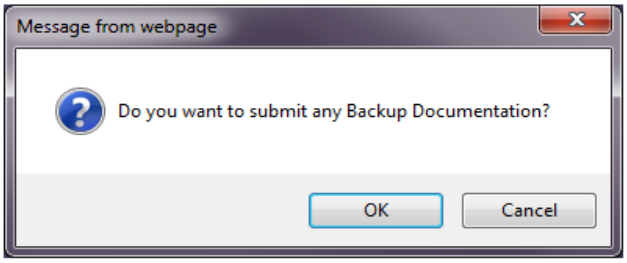


Examples of claim notes could be "Faxing Consent form," "attaching backup electronically", "sending EOB" or "mailing backup."

2) After clicking the "**Submit Claim**" button



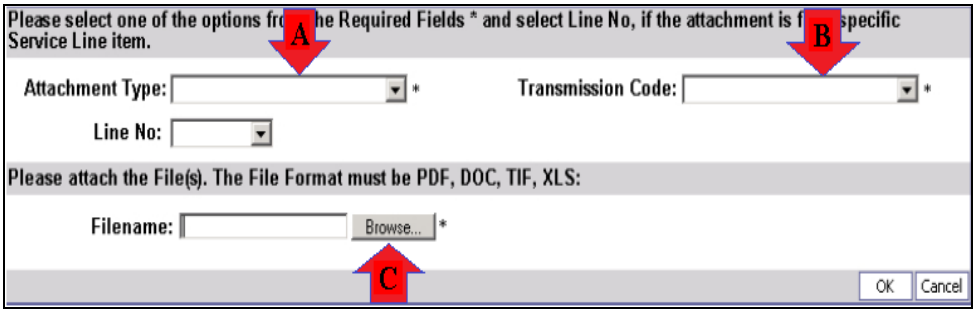
A pop-up should appear asking if you want to submit backup documentation:



Note: The appearance of the pop-up is dependent on the version of Internet Explorer being used.
Don't see the pop-up? Is the pop up blocker turned **off**?

Click the "**OK"** button to proceed with attaching backup.

3) At the Back Up Documentation screen tell us about the back up.



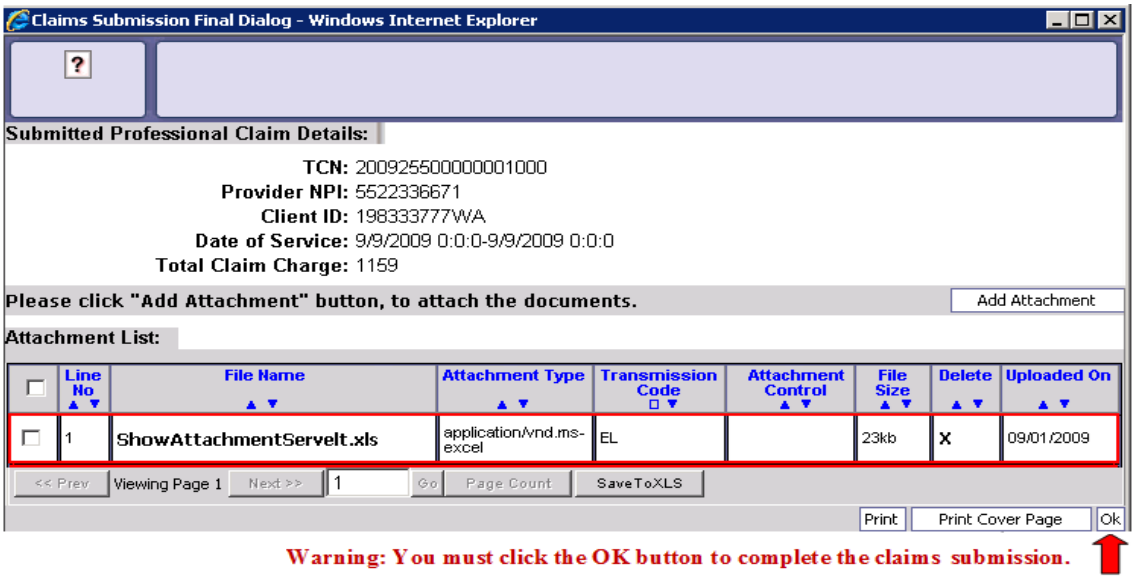
Fill in the fields:

A. Pick the Attachment Type from the drop down list.
B. The Transmission Code would be by Mail, Fax, or Electronic.
   i. Line No is not required.
C. Add an electronic attachment using the Filename field. Use the browse button to find the file on your PC to attach.

Click on the OK button when completed.

Electronic Backup

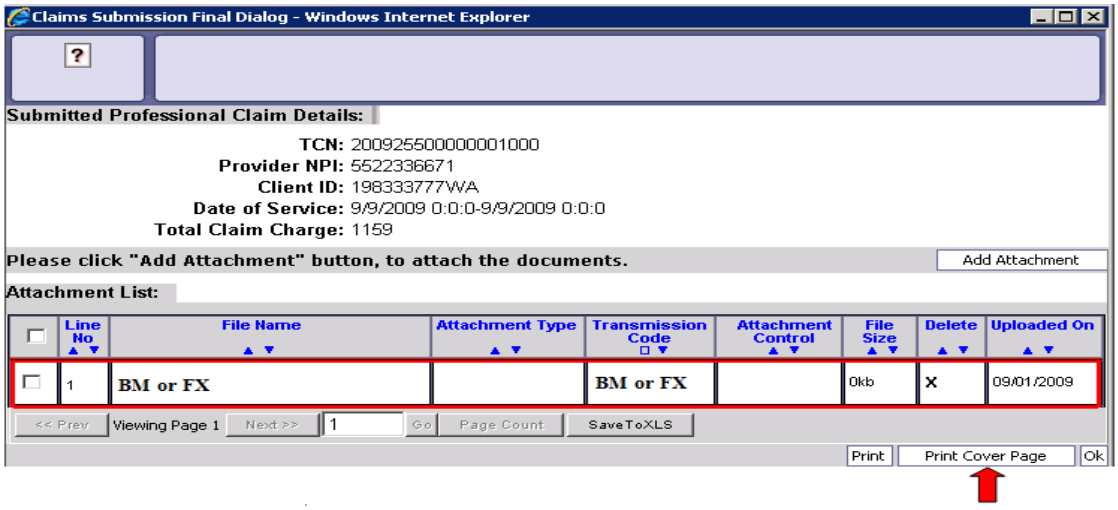
A claim sent via Direct Data Entry (DDE) in ProviderOne can have an electronic image of any backup attached to that individual claim.



This screen shows the electronic file is attached to the claim so please click the OK button to complete sending the claim.

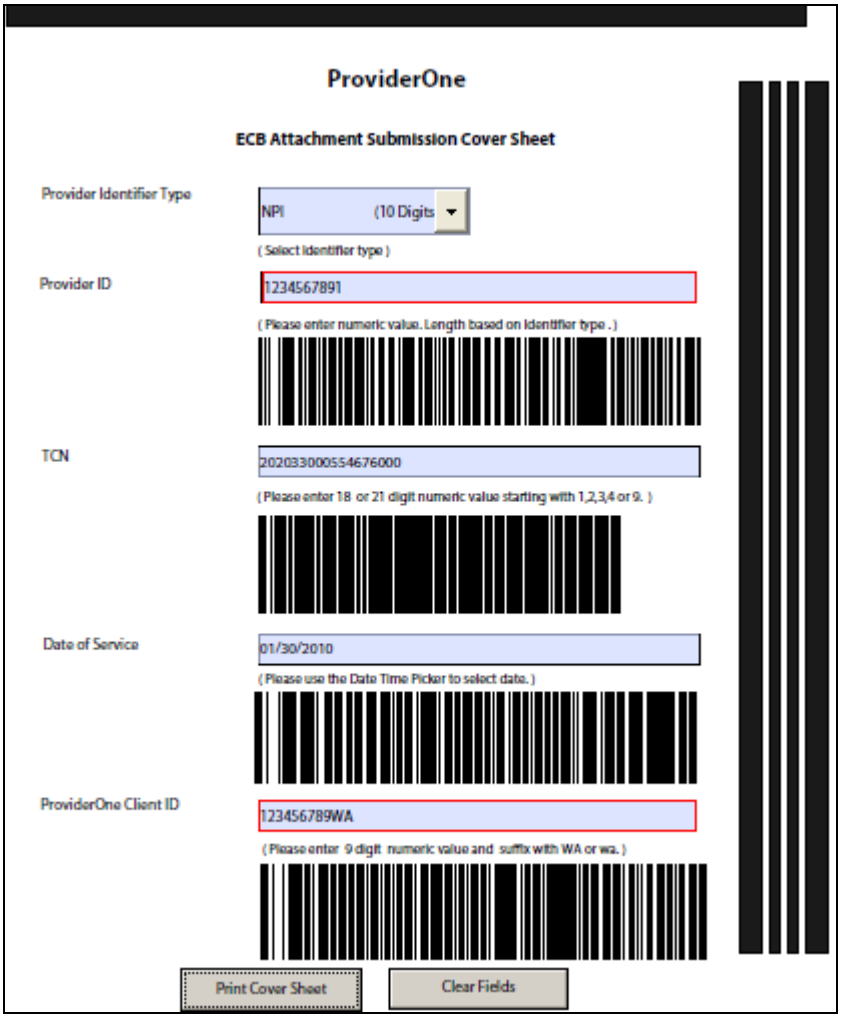
Paper Backup

Paper backup documents can be attached to the DDE claim by Fax (FX) or by Mail (BM). Create the cover sheet by clicking on the "**Print Cover Sheet"** button.



When the cover sheet downloads, fill in the information required, print and send the back up and cover sheet to the Agency at the address or fax number listed at the end of this section.

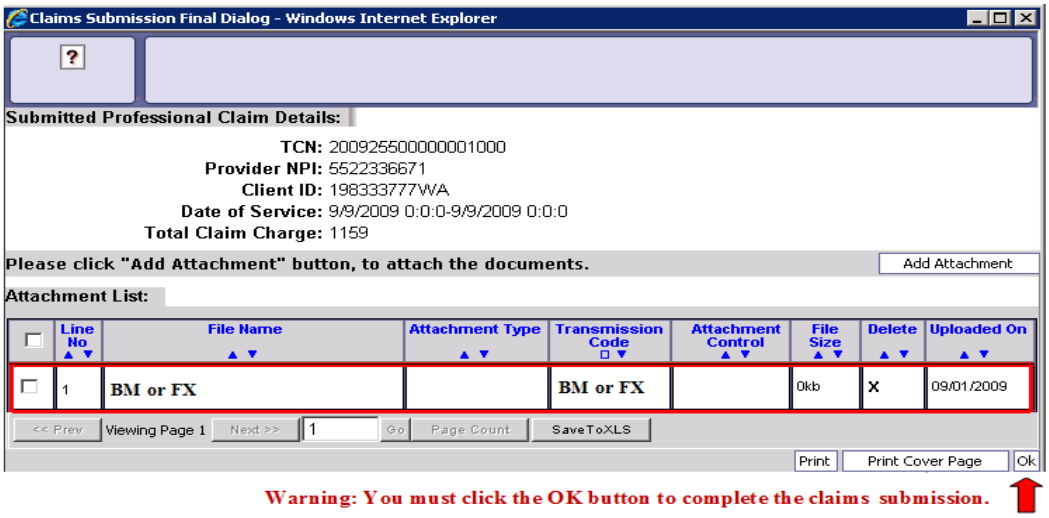
Below is an example of a cover sheet. The barcode expands to reflect the data entered once the data field is completed by simply hitting the "enter" key or moving the cursor to the next field.



- If a provider skips the above step and needs to print a cover sheet, the cover sheets can be located at http://www.hca.wa.gov/medicaid/billing/pages/document_submission_cover_sheets.aspx . All supporting documentation requires an Agency cover sheet. For more information on cover sheets, please visit Appendix G.

Note: When filling out the cover sheet, be sure to fill in all fields with information. Do not add a zero, an extra space, or any other characters to any field if the information for that field is not available when filling out the cover sheet. Obtain the information, and then fill in the fields and print. Do Not save the cover sheet for reuse as each cover sheet is specific to the document being sent to the Agency. Please do not use any software other than **ADOBE** for opening and generating the coversheet. The barcode used to link documents will not work properly using other software.

- When finished attaching backup, click "OK" to submit the claim.



Note: Electronic back up image files are limited to 2 megabytes in size.

- E-BU images can also be attached to adjusted claims.
- E-BU images can also be attached to fixed resubmitted denied claims.

- Paper backup submittal for claims submitted DDE
  - Attach a ProviderOne cover sheet to the back-up documents and send them to:

    Electronic Claim Back-up Documentation (ECB)
    PO Box 45535
    Olympia, WA 98504-5535
  - Fax to 1-866-668-1214

Submitting Backup through a Clearinghouse

Providers can submit claims through their clearinghouse then fax in their backup documents.

Note: A large amount of backup documents cannot be faxed. Mail them to the above address and don't forget the cover sheet!

1) Prepare the claim as normal and add a claim note indicating that back up is being sent for the claim. Example: "Faxing Consent Form"
2) Submit the claim normally to the clearinghouse.
3) Wait 48-72 hours to allow the claim to be received in ProviderOne and for ProviderOne to assign a TCN number to the claim.
4) There are two options to get the TCN number for the claim (s)
   a. Log into the Provider Portal and select the option for a "**Claim Inquiry**", enter the client ID and the Date of Service. The system will return all the TCNs that meet the search criteria. Find the newest TCN for your claim (the larger the TCN number the newer the claim). See Key Step 5 in this Guide for more information about claim inquiries.

b. Submit a 276 HIPAA transaction and the system will return a 277 transaction with the TCNs you are searching for. Work with your technical staff for completions of these transactions.

5) After getting the TCN number of the claim go to the Document Submission Cover Sheets page at http://www.hca.wa.gov/medicaid/billing/pages/document_submission_cover_sheets.aspx . Select the cover sheet that corresponds to the claim type being billed. Fill out the cover sheet and fax to the number on the cover sheet. Remember the cover sheet must be the first page of the fax.
6) Fax each claim's backup individually; separate from other claim backup otherwise multiple submissions may get batched under the cover sheet at the top of the batch. Be sure to turn off any settings on the fax machine that could cause it to bundle multiple documents sent to the same fax number.

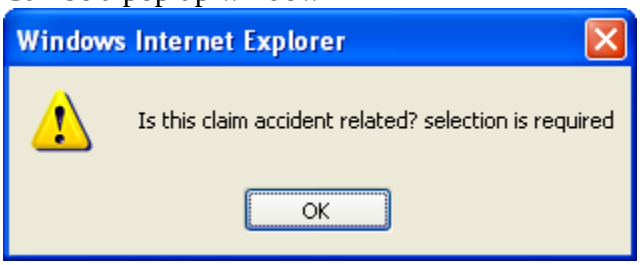
Resolving DDE claim submission errors

During the process of submitting a DDE claim, ProviderOne does a data check prior to submission to verify if all:

- Fields contain valid entries
- Required fields are completed
- Required questions are answered

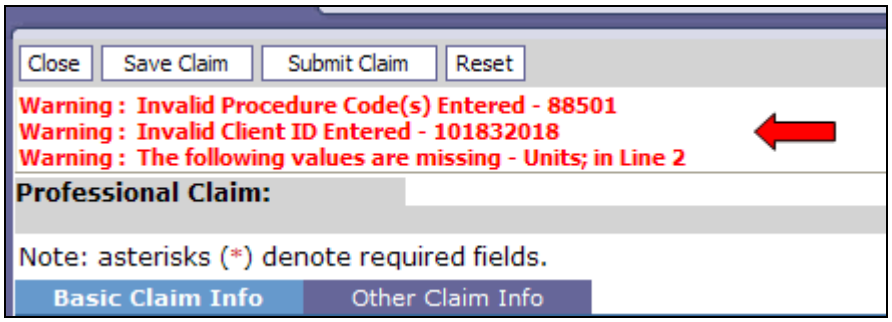
Errors can come in a two formats.

- Can be a pop up window



Go back and answer the required question missed during claim data entry.

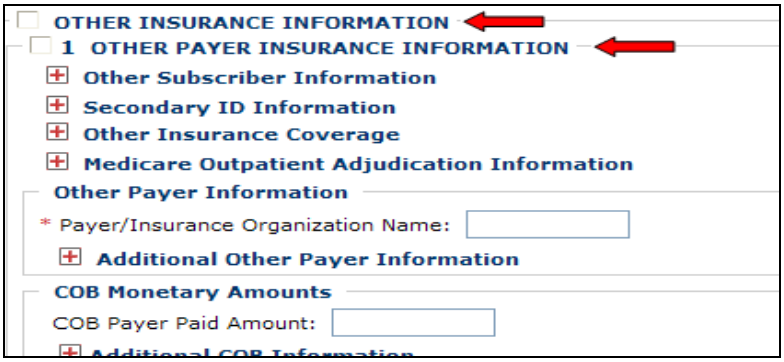
- Or can be a red text messages at the top of the claim form screen



These three errors are probably caused by hurrying during the data entry process. Fix the keying error on the code, add the "WA" to the client ID number, and add the missing unit to the service line.
Once all errors are fixed, try submitting the claim again.

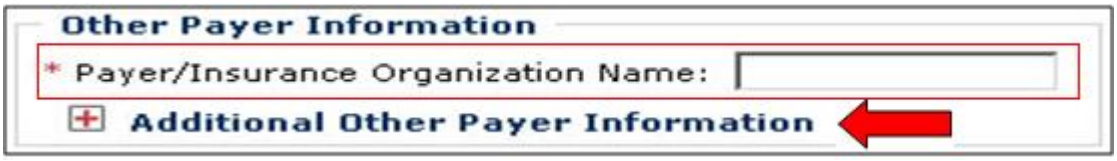
3b. Direct Data Entry - Commercial Insurance Secondary Professional Claim into ProviderOne

Under the Medicare question, expand the "**Other Insurance Information**" section.
Then expand the "**1 Other Payer Insurance Information**" expander for the first insurance. The system now has the ability for the provider to enter more than one insurance company's information.

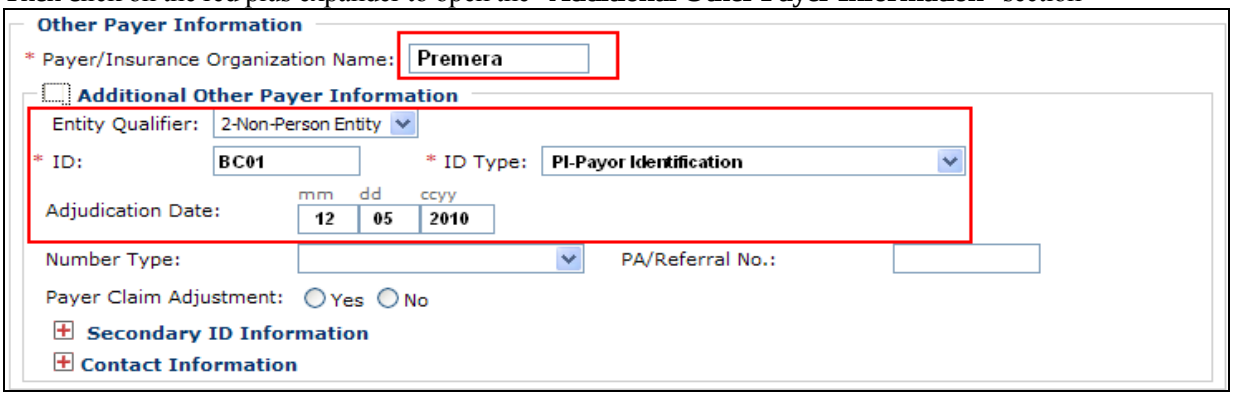


Do **not** enter Medicare or Managed Medicare (Medicare Part C) information here. HCA does not consider them commercial insurance.

When the "**1 Other Insurance Information**" screen opens, skip directly to the "**Other Payer Information**" section and enter the name of the Insurance Company.



Then click on the red plus expander to open the "**Additional Other Payer Information**" section

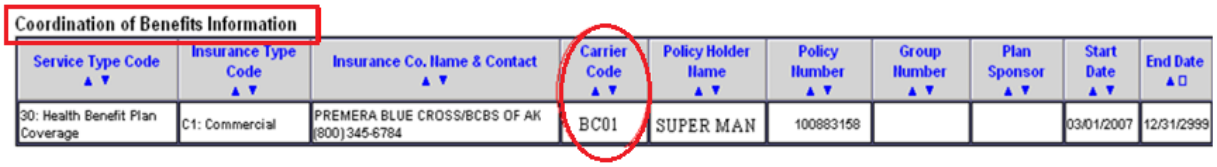


Enter the:

- Entity Qualifier
- Payer ID number
- Payer ID Type
- Adjudication (payment) Date

What is the ID number of the Insurance Company?

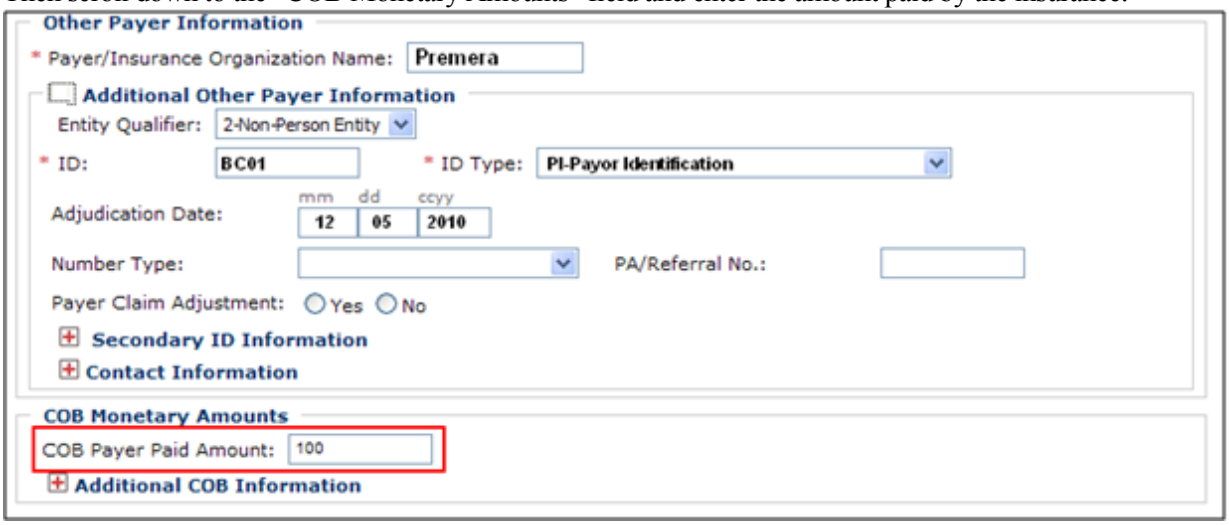
The Agency would prefer that the **Insurance Carrier Code** be used on these claims as the ID number; the carrier code can be found on the client's eligibility file in ProviderOne. Conduct an eligibility check for the client; under the Coordination of Benefits section, it would show **BC01** for this client.



Coordination of Benefits Information

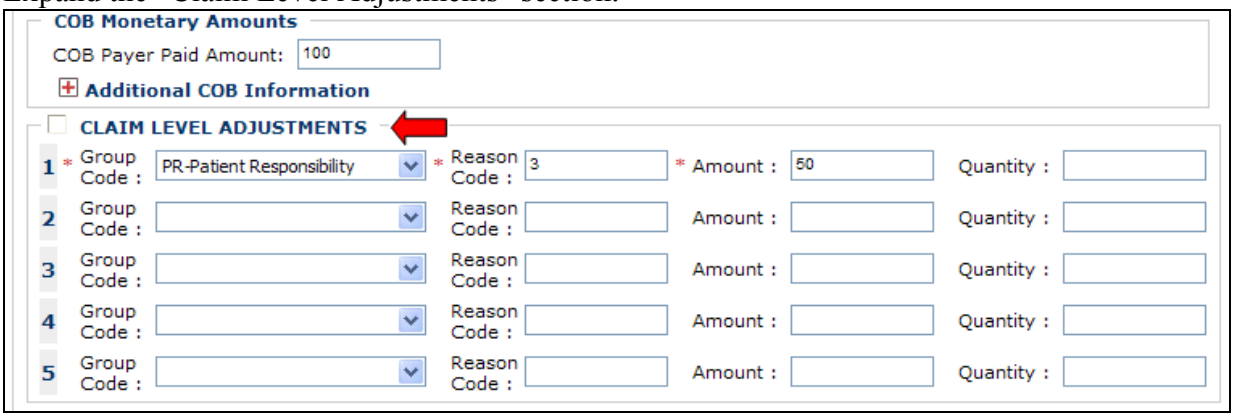
Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	PREMERA BLUE CROSS/BCBS OF AK (800) 345-6784	BC01	SUPER MAN	100883158			03/01/2007	12/31/2999

Then scroll down to the "COB Monetary Amounts" field and enter the amount paid by the insurance.



Providers can avoid sending in the insurance EOB with this claim by following the next steps.

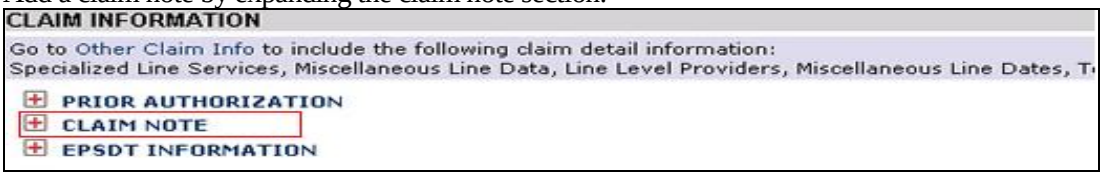
Expand the "Claim Level Adjustments" section.



Enter the HIPAA Adjustment Reason Code information from the insurance EOB:

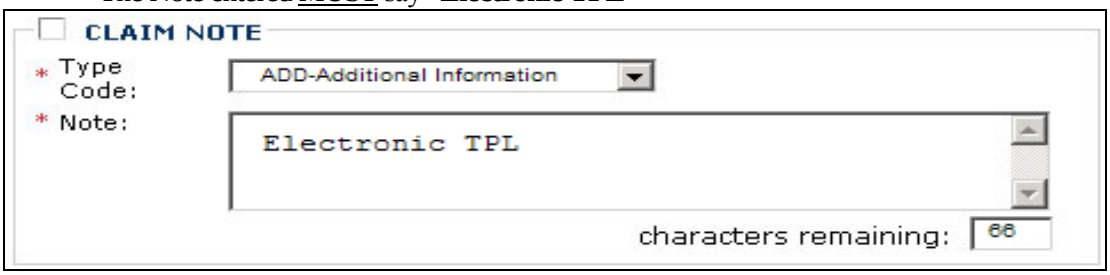
- Group Code (choose from the options)
- Reason Code (only the HIPAA reason code number is required)
- Amount (enter a zero if billing services denied by the insurance company)

Add a claim note by expanding the claim note section.



And then enter:

- Type Code will be "ADD-Additional Information"
- The Note entered MUST say "**Electronic TPL**"



Finish filling in the rest of the claim data and submit the claim as outlined above in section **3a.**

Note: Providers can use this process to submit claims or claim lines denied by the insurance company, as well as claims or claim lines paid by the insurance company. The Agency can process the claims with these data elements:

- Name of the insurance company and the Agency Carrier Code
- Amount paid by the insurance company (enter zero if no payment)
- The HIPAA Adjustment Reason Codes for payment/non-payment.

DO NOT submit DDE claims with paid lines and denied lines of service on the same claim form. Split the billing into two claims.

For more information on billing Medicaid secondary to a commercial insurance, follow along with the presentation slides for **professional, dental, and institutional** secondary claims found at http://www.hca.wa.gov/medicaid/provider/Pages/webinar.aspx .

Third-Party Liability

If the client has commercial insurance coverage (excluding Medicare), prior authorization (PA) is not required prior to providing any service requiring PA. However if the commercial insurance denies payment for the service that required PA, providers must then request authorization and include a copy of the insurance denial EOB with the request. See the PA chapter for submitting a request.
For some programs PA is required prior to the services being provided regardless who is the primary payer. Examples of this could be DME supplies and Inpatient hospital stays that require authorization. Review your specific Medicaid Provider Guide for more details.
If the primary pays the service then authorization is not required for the secondary claim.

Note: All billing methods, DO NOT submit paid lines and denied lines of service by the insurance company on the same claim form. Split the billing into two claims.

How to bill Medicare Crossover Claim via the DDE claim form is covered in Key Step 4 following this section.

3c. Saving a Direct Data Entry Claim

ProviderOne now allows a provider to save a claim if the provider is interrupted during the process of entering a claim, and allows retrieving that saved claim to finish and submit the claim. The following data elements are required to be completed before a claim can be saved:

Provider Information

- Billing Provider NPI
- Billing Provider Taxonomy
- Question: Is the Billing Provider also the Rendering Provider?
- Question: Is this service the result of a referral?

Subscriber/Client Information

- Client ID number
- Question: Is this a Medicare Crossover Claim?

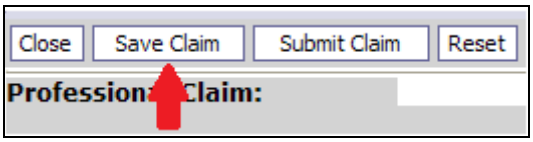
Claim Information

- Question: Is this claim accident related?

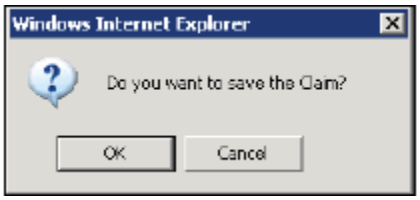
Basic Service Line Items

- Line Items are not required for saving a claim.

Save the claim by clicking on the "**Save Claim**" button.



ProviderOne now displays the following confirmation box:

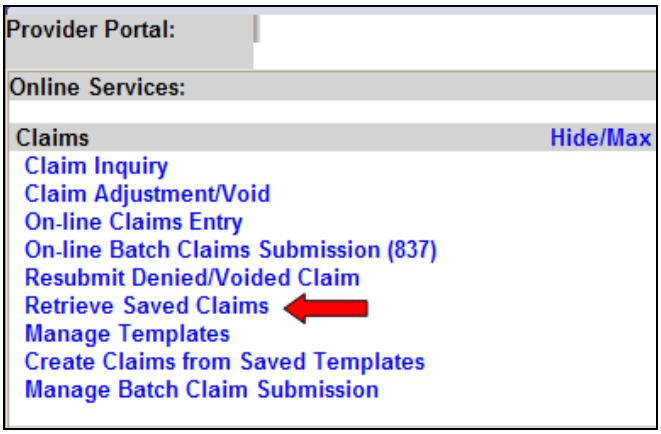


Click the OK button to proceed or Cancel to return to the claim form.

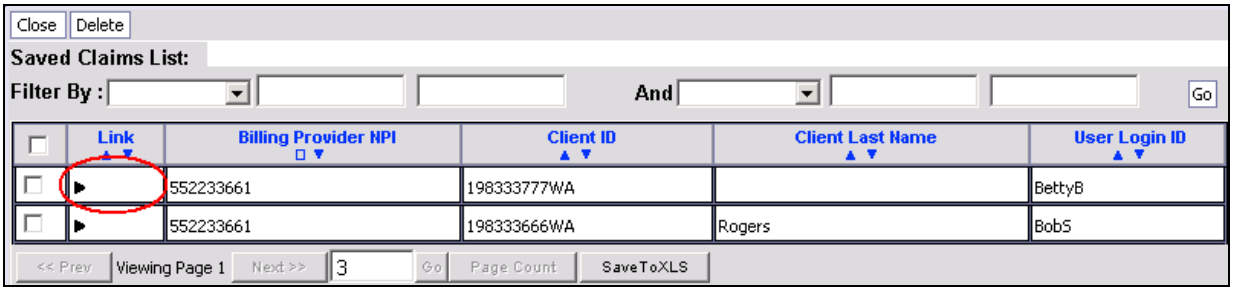
Once the OK button is clicked, ProviderOne checks the claim to make sure the minimum data fields are completed.
If all data fields are completed, ProviderOne saves the claim and closes the claim form.

Retrieving a Saved Claim

At the Provider Portal, click on the "Retrieve Saved Claims" hyperlink



ProviderOne displays the **Saved Claims List**.
Click on the **Link Icon** to retrieve a claim.

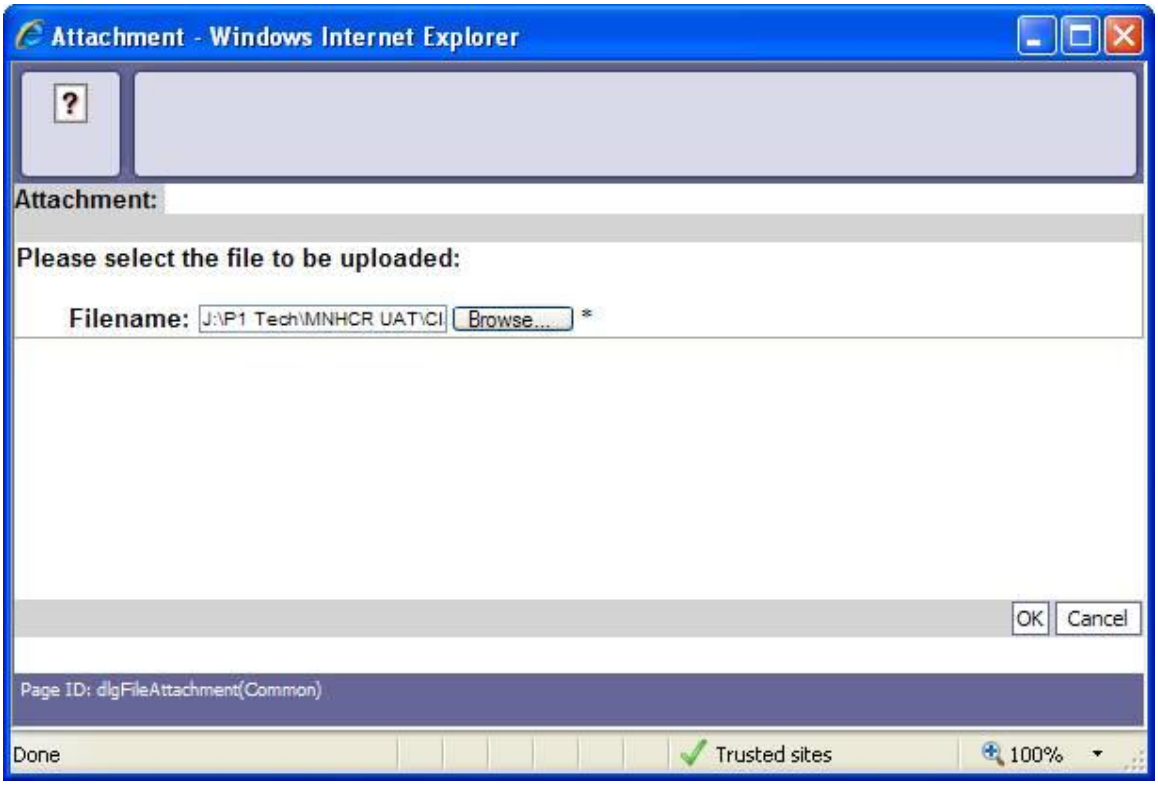


The system loads the saved claim in the Professional DDE screens. Continue to enter data, and then submit the claim.
Once a saved claim has been retrieved and submitted, it will be removed from the Saved Claim List.

3d. Online Batch Claims Submission

From the homepage, click on online batch claims submission

- Click on the **Submit HIPAA Batch Transaction** hyperlink.
- Click on the Upload button on the next screen.
- Click on Browse and locate the batch file.
- When the file name is displayed, click on the OK button
- If the upload was successful, ProviderOne displays a confirmation page – print this out and use it for reference when checking on the Batch Response (997).
- If sending in backup documentation to a claim in the batch (a TCN is required to do this), a completed and printed cover sheet is required. Cover sheets can be located at http://www.hca.wa.gov/medicaid/billing/pages/document_submission_cover_sheets.aspx . For more information on cover sheets, please visit Appendix G.



HIPAA HINTS

COMMENTS ON BATCH CLAIMS

ProviderOne has a feature that allows comments to be scanned directly into the system, without the need of a worker to manually review the claim.

To make any of the following comments, put "**SCI=**" and the corresponding letter on the list below:

- **B** – BABY ON MOMS CLIENT ID
- **F** – ENTERAL NUTRITION – CLIENT NOT ELIGIBLE FOR WIC
- **H** – CHILDREN WITH SPECIAL HEALTHCARE NEEDS
- **I** –INVOLUNTARY TREATMENT ACT (ITA) (Legal Status)
- **K** – NOT RELATED TO TERMINAL ILLNESS (Hospice Client)

- **V** – VOLUNTARY TREATMENT (Legal Status)
- **Y**– SPENDDOWN AMOUNT (and list the amount) **(837P only)**

BILLING MEDICAID AS THE SECONDARY PAYER USING HIPAA BATCH FILES

Providers can use an 837 transaction to electronically submit to the Agency the primary payer insurance information. Please follow the guidelines within the ProviderOne 837 Professional, Institutional and Dental Companion Guides at http://www.hca.wa.gov/medicaid/hipaa/pages/index.aspx

Avoid sending in back-up documentation from the primary insurance by 1) adding the comment "**Electronic TPL**" in the remarks field (Loop 2300 NTE Segment), AND 2) send in the appropriate adjustment reason code information about the action the primary payer took within the appropriate loops and segments.

3e. Paper

Guidelines/Instructions for Paper Claim Submission:

- In order for the claim to be read by the Optical Character Reader (OCR) feature of the scanner, the blank claim form must be a commercially produced form with:
  - Either Sinclair Valentine J6983 or OCR Red Paper using these scan-able red inks. These inks cannot be duplicated by a computer printer.
  - Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid, or tape anywhere on the claim form or backup documentation. The red ink will not be picked up in the scanning process and the highlighter could turn into a dark square covering the highlighted information.

- Use standard typewritten fonts that are 10 C.P.I (characters per inch).
  - Do not mix character fonts on the same claim form.
  - Do not use italics or script.

- Use black printer ribbon, ink-jet, or laser printer cartridges.
  - Make sure ink is not faded or too light.
  - Use of Dot Matrix printers may compromise the print quality.

- Ensure all the claim information is entirely contained within the proper field on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- For multiple page claims, please designate the page number on each page in the lower right hand corner. Put this information (e.g. 1 of 5, 2 of 5, 3of 5, etc.) in the white space at the very bottom of the claim form. This will help multiple page claims from being separated. The total dollar amount needs to be on page one for all combined pages. You can leave the subsequent totals blank.

See Appendix I for detailed instructions on filling out the CMS-1500 claim form.
See Appendix J for detailed instructions on filling out the UB-04 claim form.
See Appendix K for detailed instructions on filling out the 2006 ADA claim form.

Providers should submit their paper claims to the following address:

All Paper Claims
Medical Assistance, attention: Claims
PO Box 9248
Olympia, WA 98507-9248

Note: The Agency will not accept hand written claim forms. In addition, copied claim forms will not be accepted.

Note: For electronic billers, all data elements required on a paper claim form are the same on the electronic billing. Use the Appendix(s) as a data element location reference.

Pitfalls

- **Failing to use the National Provider Identifier (NPI) that the Agency has on file. This can cause the claim to be denied.**
- **Failure to use a proper taxonomy code. This can cause the claim to be denied.**
- **Failure to include gender on the claim. This can cause the claim to be denied.**
- **Highlighted information on the paper claim form. This may cause vital data to not be recognized in the OCR process, resulting in possible claim denial.**
- **Using stamps, stickers, or comments that say, "REBILL," "TRACER," or "SECOND SUBMISSION" or similar statements on any claim. These notes cannot be processed.**
- **Failing to indicate the baby's name, birth date and gender on a newborn claim using mom's ID. This can cause the claim to be denied.**
- **Forgetting to hit the "OK" button on the bottom of the last pop-up on the DDE screens. If a claim is submitted DDE and the system assigned it a TCN, but the TCN cannot be found in the system, the submitter forgot to click the final "OK" button on the bottom of the last pop-up screen. Do not exit out of this pop-up as exiting out will result in the claim not being submitted.**
- **Failure to turn off the pop up blocker when using ProviderOne. The submitter will not be able to finish submitting a Direct Data Entry claim if the pop up blockers are turned on.**
- **Forgetting to hit the "Enter" key or to click outside any field when filling out the cover sheet. The cover sheet will not then contain the proper barcodes and the backup will not be attached to the DDE claim in ProviderOne.**
- **Saving a filled out cover sheet. Do not save used cover sheets, as each cover sheet has unique coding for the claim the backup documents are to be attached to.**
- **Submitting paper claims. Electronic claims process much faster than paper claims.**

Key Step
4

4. Submit Medicare Crossover Claims

Why

"Medicare Crossover Claims" are claims for the client's Medicare cost sharing liability (deductible, coinsurance, or copay). Claims denied by Medicare are not crossover claims and this key step does not apply to these non-crossover claims.

This key step covers how crossover claims are submitted to and processed by the Agency. Managed Medicare claims (Medicare Part C or Medicare Advantage) must also be billed as crossover claims. Please use the instructions in this key step when billing Managed Medicare claims.

How

In most cases, after processing the claim for payment, Medicare will forward the claim electronically to the Agency and include a message on your Explanation of Medicare Benefits (EOMB) stating: "This information is being sent to either a private insurer or Medicaid." The Agency then processes these crossover claims without any action on the provider's part.

Sometimes Medicare does not forward claims automatically to the Agency, so providers may have to bill the crossover claim directly to the Agency. Paper crossovers submitted directly to the Agency will require a copy of the EOMB.

The Agency recommends billing claims electronically or using ProviderOne DDE for faster processing. DDE crossovers claims do not require the EOMB.

Providers will know if Medicare has not forwarded the crossover claim to the Agency if:

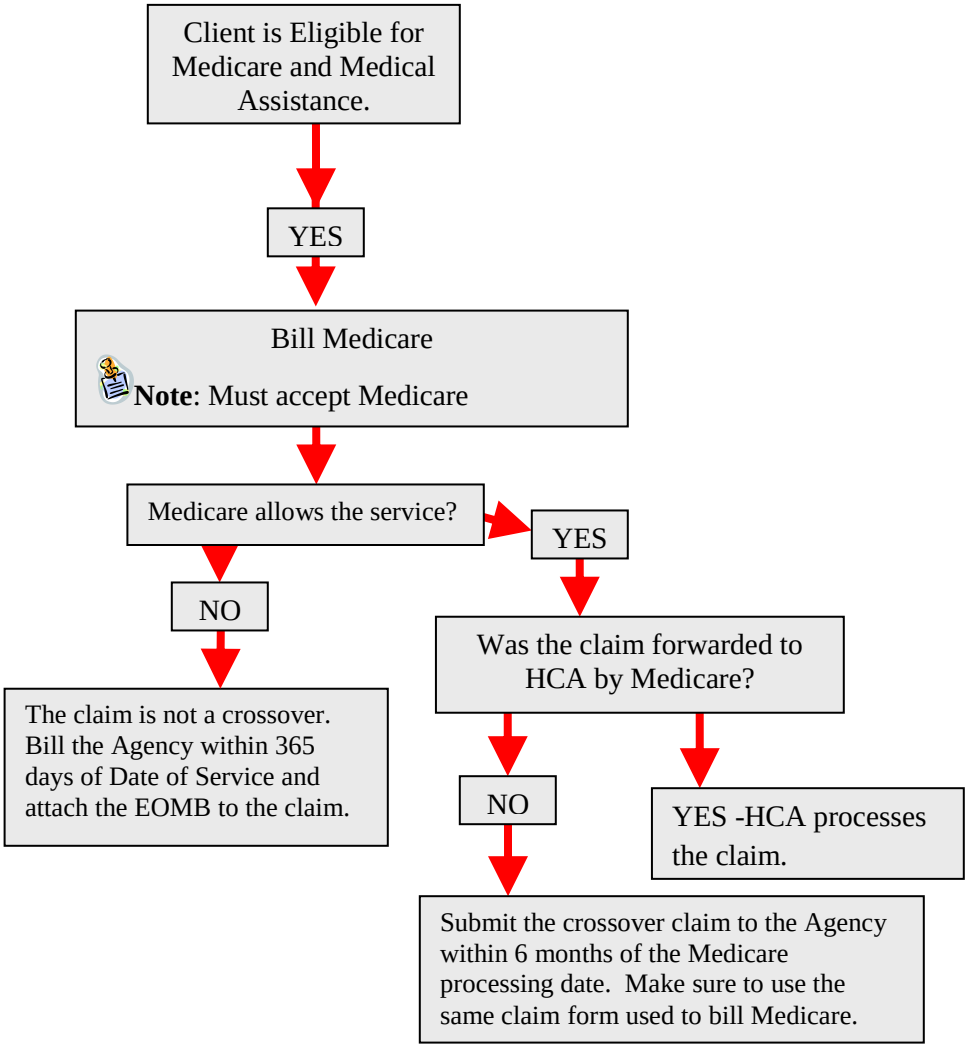
- It does not show up on the Medical Assistance Remittance Advice; or
- The message "This information is being sent to either a private insurer or Medicaid" does not show up on the EOMB.

Some of the reasons Medicare may not forward a crossover claim directly to the Agency include:

- The patient may be a new Medicare/Medicaid enrollee and Medicare does not yet list them as having Medicaid coverage.
- The provider billed Medicare with an NPI number that has not been reported to the Agency.
- There are Electronic file corruption issues.
- Managed Medicare (Medicare Part C or Medicare Advantage Plans) may not forward claims directly to the Agency

See Appendix M for payment methodology information on crossover claims.

Overview of Medicare Crossover Process



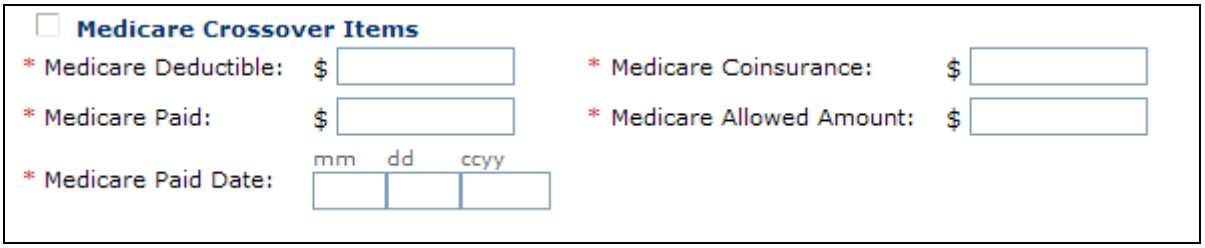
The next section explains how each type of Medicare crossover claim is submitted to the Agency if the claim is not automatically forwarded by Medicare. Please see Appendix M for crossover payment methodologies.

Medicare Part B Professional Services (CMS-1500, 837P)

- If Medicare has paid all lines on the claim, submit the crossover claim to the Agency.
- If Medicare has allowed and denied services lines on the claim, do not submit paid lines with denied lines to the Agency on the same claim form; this could cause a delay in payment or claim denial. Submit 2 claims to the Agency - one crossover claim for services Medicare paid and one professional claim for services Medicare denied.
    - If Medicare bundled the service into another paid service line, do not split out or unbundle to bill Medicaid.
    - Attach the EOB to the claim for services denied by Medicare and enter a claim note "**Sending denial EOB**" to alert the Agency that back is being sent.
- If Medicare denies a service that requires **PRIOR** authorization (PA) by the Agency, the Agency waives the **PRIOR** requirement but still requires authorization based on medical necessity, which may be requested after the service is provided.
- If Medicare applies to the deductible or makes payment on a service that required PA, then authorization is not required for the service.
- Bill the Agency on the same claim form billed to Medicare with the same services and billed amounts.
- Bill Medicare with the appropriate Agency taxonomy code for the claim according to Medicare guidelines. Medicare will then forward the taxonomy on the claim to the Agency.
- If billing DME rental codes that require a date span, please bill Medicare with the appropriate date span. Medicare will then forward the date span on the claim.

When submitting a Direct Data Entry (DDE) professional services crossover claim in ProviderOne, fill out the additional Medicare information at the line level for each line:

- Click the expander to open the "Medicare Crossover Items" fields. This includes Managed Medicare (Medicare Advantage Plans Part C).
- Fill in the Medicare information required in the now open fields then;
- The rest of the claim form is filled out per normal.



Note: If the Medicare Advantage or Part C Plan indicates an allowed amount for the service but does not make a payment on the service, enter the

- Copayment; or
- Coinsurance; or
- Patient Responsibility

As the deductible if the plan EOB indicates a remark code of copayment for the service. ProviderOne requires a deductible amount in this case to process the claim.
Example EOB:

DATES OF SERVICE	SVC PROVIDED/PPS	BILLED AMOUNT	ALLOWED AMOUNT	PAID AMOUNT	PATIENT LIABILITY	DISALLOWED AMOUNT	EOP CODES
120710-120710	99212	60.00	39.23	0.00	39.23	20.77	3 45
CLAIM TOTAL:		60.00	39.23	0.00	39.23	20.77	
SUMMARY TOTAL:		60.00	39.23	0.00	39.23	20.77	

EXPLANATION OF CODES

3 Co-payment Amount

45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

Note: If you bill a crossover electronically or DDE, the Agency does not require the EOMB.

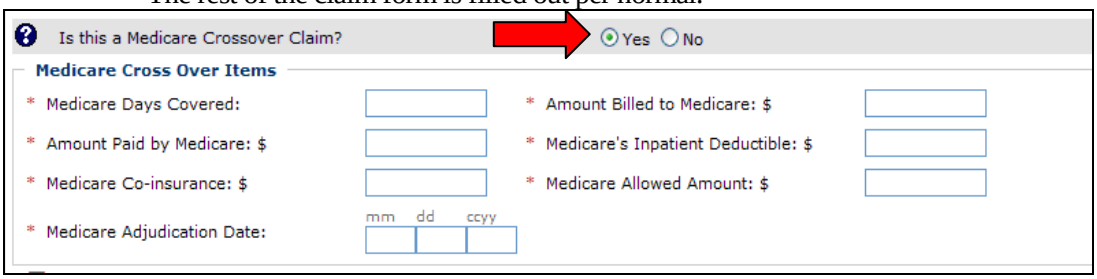
Medicare Part A Institutional Services (UB-04, 837I)

A provider that bills Medicare (or the Medicare Part C Plan) on the UB-04 claim form bills the Agency crossover claims on the same claim form. Include the same services and billed amounts sent to Medicare and attach the Medicare EOB to paper claims. A provider can:

- Submit DDE crossover claims in ProviderOne. DDE claims do not require the EOB.
- Send in paper claims with the EOB. Electronic claims (HIPAA batch and DDE) process much faster than submitting paper.

When submitting a DDE institutional crossover claim in ProviderOne, fill out the additional Medicare information at the claim level:

- Click the Radio button "yes" (Yes) to indicate this claim is a crossover
- Fill in the Medicare information required * in the now open fields then;
- The rest of the claim form is filled out per normal.



Note: While claims for clients that do not have Medicare Part A or Part A benefits are exhausted are not considered **crossover claims**, we have included how to bill these claims in this section.

How Do I Bill for Clients Covered by Medicare Part B Only (No Part A), or Has Exhausted Medicare Part A Benefits Prior to the Stay?

Description	DRG	Per Diem	RCC	CPE	CAH
Bill Medicare Part B for qualifying services delivered during the hospital stay.	Yes	Yes	Yes	Yes	Yes
Bill the Agency for hospital stay as primary.	Yes	Yes	Yes	Yes	Yes
Show as noncovered on the Agency 's bill what was billed to Medicare under Part B.	No	No	Yes	Yes	Yes
Expect the Agency to reduce payment for the hospital stay by what Medicare paid on the Part B bill.	Yes	Yes	No	No	No
Expect the Agency to recoup payment as secondary on Medicare Part B bill*.	Yes	Yes	No*	No*	No*
Report the Part B payment on the claim in the other payer field "Medicare Part B"	Yes	Yes	No	No	No
Attach Medicare Part A & B EOB to claim	Yes	Yes	Yes	Yes	Yes
Include a claim Note**	Yes	Yes	Yes	Yes	Yes

* The Agency pays line item by line item on some claims (RCC, CPE, and CAH). The Agency does not pay for line items that Medicare has already paid.
The Agency pays by the stay (DRG claims) or the day (Per Diem) on other claims. The Agency calculates the payment and then subtracts what Medicare has already paid. The Agency recoups what it paid as secondary on the Medicare claim.
**The claim note should be one of these:

- No Part A Benefits; or
- Part A Benefits exhausted prior to stay

What the Agency Pays the Hospital:

DRG Paid Claims:
DRG allowed amount minus what Medicare paid under Part B. When billing put the Part B payment amount in the TPL commercial insurance field and indicate the primary payer as Medicare Part B.

Per Diem Paid Claims:
Per Diem allowed amount minus what Medicare paid under Part B. When billing put the Part B payment amount in the TPL commercial insurance field and indicate the primary payer as Medicare Part B.

RCC, CPE and CAH claims:
Allowed amount for line items covered by the Agency (line items usually covered by Medicare under Part A, if client were eligible).

How Do I Bill for Clients when Medicare coverage begins during an Inpatient stay or Part A has exhausted during the Stay?

1. Bill Medicare
   - Medicare PPS Payment Manual, Chapter 3, Section 40A, bullet 3.

   "The beneficiary becomes entitled after admission. The hospital may not bill the beneficiary or other persons for days of care preceding entitlement except for days in excess of the outlier payment."
2. The Agency must have a paid/billed inpatient crossover claim in the system.
3. After the IP crossover is paid, bill HCA the primary claim for the entire stay.
   - If billing RCC, CPE or are a CAH list the Medicare covered day's charges as non-covered.
   - If billing DRG or Per Diem list all services (no non-covered).
4. If Part A exhausts during the stay you must still bill Medicare for the Part B charges.
5. The Agency may pay something using the following formula:
   - (HCA allowed for the entire stay – Medicare paid – HCA crossover payments).
6. Add the following claim Note:
   - "Part A Benefits exhausted during stay"; or
   - "Medicare Part A coverage began during the stay".
   - Enter the Part A start date or the date benefits are exhausted in the Occurrence fields using Occurrence Code A3 then enter the date.
7. Attach Part A and Part B Medicare statements (EOB).
8. These claims can be very complex and are addressed on a case by case basis and sometimes it is necessary for the Agency to contact the biller for additional information.

Medicare Advantage Plans (Part C)

Some Medicare clients have elected to enroll in a Medicare HMO plan called a Medicare Advantage Plan (Part C) and providers are required to bill these Medicare Advantage Plans instead of FFS Medicare. The Managed Medicare – Medicare Advantage Plan is the primary payer and is not considered commercial insurance by the Agency.

- In order to receive payment from the Agency, it is necessary to follow the billing guidelines established by the Managed Medicare – Medicare Advantage (Part C) Plans prior to billing the Agency.
- After the Medicare Advantage plan processes the claim, submit the claim to the Agency as a Medicare crossover claim. Bill the Agency with the same claim type used to bill the Medicare Advantage plan. Make sure the services and billed amounts match what was billed to the Medicare Advantage plan. Direct Data Entry (DDE) claims do not require the EOB to be sent with the claim.
- The Agency must receive the Medicare Advantage claim within 6 months of the Medicare Advantage payment date.
- If Medicare Advantage denies a service that the Agency requires **PRIOR** authorization (PA) for, the Agency waives the **PRIOR** requirement but will require authorization which may be requested after the service is provided. The Agency waives the "prior" requirement in this circumstance.
- If the Medicare Advantage plan pays the service then PA is <u>not</u> required.

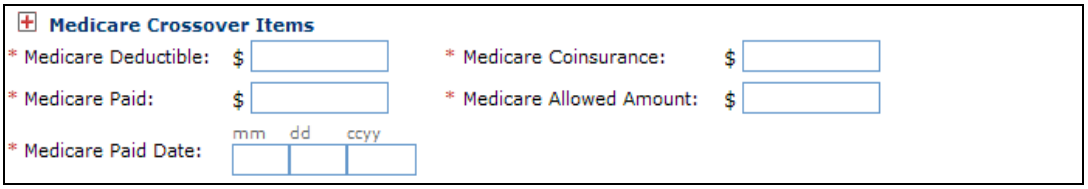
Billing for Managed Medicare – Medicare Advantage (Part C) Plans

If there is a capitated Copayment due on a claim:

Claims for Capitated copayments for the Medicare Part C Plan must now be billed as a crossover claim type (professional and institutional claims).
If no "Medicare (plan) Allowed Amount" is provided, enter the sum of:

- Payment + Copayment + Coinsurance + Deductible

as the "Medicare Allowed Amount". If there is no amount for an entry, just add together the entries that do have an amount.



- Finish filling in the other amounts (even if they were used to calculate an allowed amount).
- Enter a zero (0) in any other fields without a value.
- If the user entered a zero (0) in the "Medicare Paid" field, then enter the Co-pay amount in the "Medicare Deductible" field as ProviderOne requires a deductible if the plan allowed the service but pays at zero (0).

Comments are no longer required on the claim.

Claims with a coinsurance, deductible, or a non-capitated copayment balance due on a claim.

Professional Services

- Bill the claim paid by the Part C Plan as a cross over claim.
- If the Part C Plan lists a copay amount but no coinsurance amount, enter the copay amount in the coinsurance field on the crossover claim submitted to HCA.
- If the Medicare Advantage or Part C Plan indicates an allowed amount for the service but does not make a payment on the service, enter the
  - Copayment; or
  - Coinsurance; or
  - Patient Responsibility
- As the deductible if the plan EOB indicates a remark code of copayment for the service. ProviderOne requires a deductible amount in this case to process the claim. See page 101 above for an example of this type of a Plan EOB. If Medicare Advantage has allowed and denied services lines on the claim, do not submit paid lines with denied lines to the Agency on the same claim form; this could cause a delay in payment or claim denial. Please submit 2 claims to the Agency, one crossover claim for services Medicare paid and one professional claim for services Medicare denied.
  - If Medicare bundled the service into another paid service line, do not split out or unbundle to bill Medicaid.
  - Attach the EOB to the claim for services denied by Medicare and enter a claim note "**Sending denial EOB**" to alert the Agency that backup is being sent.
- If Medicare Advantage denies a service on a claim, the Agency may or may not make a payment on the service, depending on the reason for the Medicare Advantage Plan denial.

Institutional Services

Follow the directions above for sending a Part C Plan institutional crossover claim. The only difference is you cannot split out specific lines denied by the Part C Plan and bill those lines separately. Institutional claims are processed as one entire claim.

QMB – Medicare Only Clients

- If Medicare or the Medicare Advantage Plan and Medical Assistance cover the service, the Agency pays only the client's cost sharing liability (deductible, and/or coinsurance, and/or copayment) up to the Medical Assistance allowed amount. Payment is based on the Medical Assistance allowed amounts minus any prior payment made by Medicare or the Medicare Advantage Plan. At this point the Agency considers the crossover claim paid in full.
- If Medicare or the Medicare Advantage Plan covers the service but the Agency does not, the Agency will deny the crossover claim.
- If Medicare or the Medicare Advantage Plan does not cover the service, the Agency does not pay for the service.

Note: Discrepancies, disputes, protests, or justifications for a higher fee or payment for any claim should be directed to Medicare or the Medicare Advantage plan. If Medicare or the Medicare Advantage Plan adjusts the payment and the claim has previously been paid, submit an adjustment request to the Agency. Submit a new claim if the original claim was denied

Cross over claims with back up

For cross over claim billing clarification, the Agency requires the following information on the EOB:

Header (claim) level information on the EOMB must include all the following:

- Medicare (or the Part C Plan) as the clearly identified payer;
- The Medicare claim paid or process date;
- The client's name (if not in the column level);
- Medicare Reason codes; and
- Text in font size 11 or greater

Column level labels on the EOMB for the HCFA-1500 (CMS-1500) must include all the following:

- The client's name
- Number of service units (whole number) (NOS)
- Modifiers (MODS)
- Allowed amount
- Amount paid by Medicare (PROV PD)
- Date of service
- Procedure Code (PROC)
- Billed amount
- Deductible
- Medicare Reason codes

EOBs must include a written description of the Reason/Remark codes.

Column level labels on the EOMB for the UB-04 must include all the following:

- The client's name
- Billed amount
- Co-insurance
- Medicare Reason codes
- From and through dates of service
- Deductible
- Amount paid by Medicare (PROV PD)
- Text that is font size 11

Rural Health Center (RHC) and FQHC providers must include their per diem rate.
EOBs must include a written description of the Reason/Remark codes.

Claims for services denied by Medicare with back up

When Medicare or the Part C Plan denies services that can be billed to Medicaid, the above criteria applies to the required EOB sent with the claim.

Medicare Prescription Drug Program

For more information on the Medicare Prescription Drug Program, Please review the Prescription Drug Program Billing Instructions.

Pitfalls

- **Billing Medicare with an NPI that has not been reported to the Agency. The Agency will not be able to identify the provider when these claims are forwarded by Medicare to the Agency.**
- **Submitting crossover claims on paper. Paper claims process slower than other claim submission methods.**
- **The claim form billed to Medicare does not match the claim form billed to the Agency. The claim will be denied.**
- **The coding and dollar amount billed on the claim to Medicare does not match the coding and dollar amount on the claim billed to the Agency. The claim will be denied.**
- **Failing to bill the paid Part C plan claim as a cross over claim type.**
- **Not putting a claim note on the claim when Medicare denies the service or sending the Medicare EOB with the claim.**
- **Sending an EOB with the claim that does not indicate Medicare (or a Part C Plan) as the payer or other missing required information.**

Key Step
5

5. Inquire About the Status of a Claim

Why

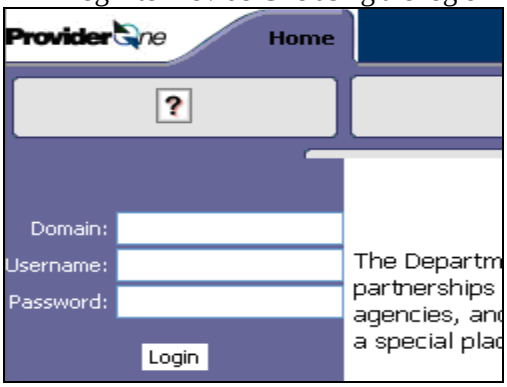
ProviderOne allows several options to search for a claim's status. A provider may want to check a claim because:

- A claim has been submitted and Medical Assistance has not responded.
- A provider is trying to re-bill some older claims and needs the Transaction Control Number (TCN) to prove timely submission of the original claim.
- A provider is searching for a claim because their accounts receivable system does not yet show a posted payment.

How

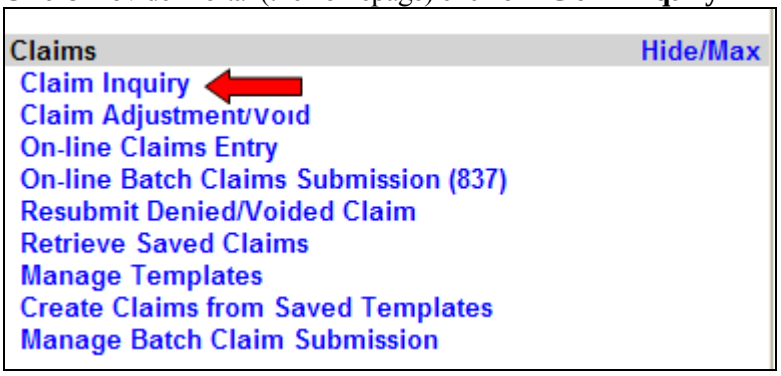
The easiest method to find claims in ProviderOne is to use the Claim Inquiry option at ProviderOne Home page option list.

- Log into ProviderOne using the log on information furnished by the office administrator.



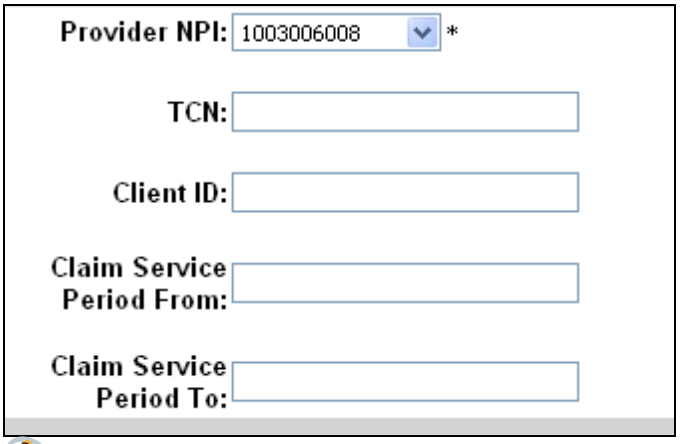
Select the **EXT Provider Claims/Payment Status Checker** or **EXT Provider Super User** profile.

On the Provider Portal (the homepage) click on "**Claim Inquiry**"



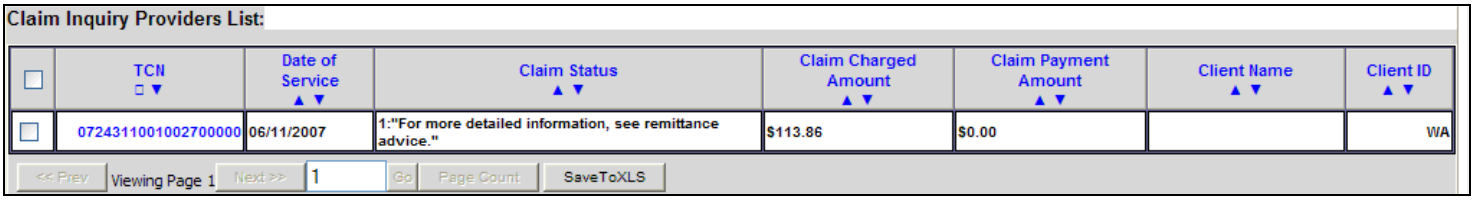
Select the appropriate NPI from the drop-down box and enter available information in the remaining fields before clicking submit.

- Required: TCN or Client ID and Claim service period (To date is optional).
- A provider may request status for claims processed within the past four years.
- The claim Service Period From and To date range cannot be greater than three months.



Note: To find a claim (or a list of claims) use the Client ID and the oldest "From" date of service on the claim. All claims for that date of service should be listed. Searching by the TCN only shows one claim and it may not be the one the provider is looking for.

After clicking on submit, the claim(s) list screen will be displayed. Click on the blue Transaction Control Number (TCN) hyperlink to view the claim



See Appendix N for instructions on checking claim status via the Interactive Voice Response (IVR).

Pitfalls

- **Calling the Medical Assistance Customer Service Center to check on the status of a claim. Providers can easily check on a claim status by using ProviderOne or the Interactive Voice Response (IVR).**

Key Step
6

6. Adjust, Resubmit, or Void a Claim

Why

The Agency does not process "corrected claims" so the only way to replace or correct a paid service or claim is through the claim adjustment process.

Adjust/Replace a paid claim when:
- A billing error was made (e.g., wrong client, billed amount, tooth number, etc.).
- The claim contained multiple surgical procedure codes, and one of the procedures was denied or paid incorrectly.
- The claim was overpaid (this may be a void claim)

Denied claims can be resubmitted using the ProviderOne resubmit feature and fixing the error that caused the original denial. Providers also have the option to re-bill a denied claim fixing the original denial error.
ProviderOne will not allow adjusting a denied claim and a claim void will not remove the claim from the system.

How

Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 24 months from the date of service (WAC 182-502-0150). A timely claim is one that meets the Agency current initial timeliness standard which is 365 days from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

There are various methods to modify, adjust, or void claims depending on the billing format (HIPAA, DDE, paper):
- If the claim was paid or partially paid then an adjustment to the claim will be needed in order to make any corrections or modification to the original claim.
  - DDE - Log into ProviderOne, select the **EXT Provider Claims Submitter** or **EXT Provider Super User** profile, and use the online Claim Adjustment/Void option or
  - Fill out the paper claim form indicating an adjustment or a void (see below) or
  - Submit a HIPAA batch transaction claim using a frequency 7 to adjust/replace the original claim or a frequency 8 to void the original claim. Follow the ProviderOne companion guides rules for submitting frequency 7 - adjust claim or 8 - void claim transactions.

- If the claim was denied (no lines were paid) and no longer meets the initial 1 year timeliness rule, then proof of timely filing is required to resubmit.
  - Locate the timely TCN number using the ProviderOne claim status search option or review a Remittance Advice

- DDE claim, resubmit the original claim. If it is not possible to resubmit the original claim, enter the timely TCN number in the comments field of the new claim ("timely TCN 12345678901234567").
- HIPAA batch claim transactions. Follow the ProviderOne companion guides rules for entering the timely TCN number.
- Paper claims note the placement of timely TCN numbers in the following sections listing how to fill out each type of claim form.

 **Note:** If a claim was originally paid then subsequently adjusted/replaced and paid and it is necessary to reprocess the claim for a third time (or fourth, fifth, etc.) it will be necessary to adjust/replace the LAST TCN in the claim trail. Once a claim TCN has been adjusted it cannot be adjusted or resubmitted again.

The General Adjustment Process

The ProviderOne system assigns an 18 digit Transaction Control Number (TCN) to each claim received. This TCN is part of the information sent to providers on their Remittance Advice (RA), has its own column, and is commonly referred to as the "claim number".

Reading the TCN

Each of the 18 digits in the claim number has a reserved meaning representing the following:

1	0	08183	0	0000001	000
A	**B**	**C**	**D**	**E**	**F**

A: Claim Medium Indicator

- 0 – Not used
- 1 – Paper
- 2 – Direct Entry (Web Submission)
- 3 –Electronic (X12)
- 4 – System Generated
- 5-8 – Reserved

A **9** in the claim medium indicator field represents a claim that was billed in the Legacy (old payment) system. These TCNs are 21 digits long.

B: Type of claim

Placeholder number that could be one of the following:

- 0 – Medical
- 1 – Pharmacy
- 2 – Crossover or Medical
- 3 – Medical Encounter
- 4 – Pharmacy Encounter
- 5 – Social Services
- 6-9 – Reserved

C: Batch Date

- First two digits are the year (08)
- The next 3 numbers are the Julian day of the year with 183 being July 2nd. The Agency utilizes the Julian calendar to record the date claims were received. The Julian calendar is simply a continuous counting of the days of the year from 1 to 365. Remember Leap Years!

D: Adjustment Indicator

- 0 – Original Claim
- 1 – Adjustment (credit)

E: Claim Sequence Number

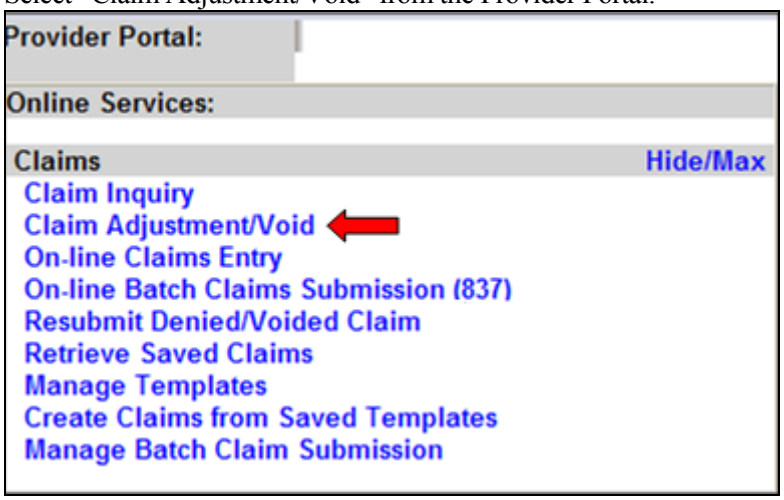
- Sequential counting of claims each day starting with 0000001
- Allows claim counting to reach almost 10 million, 9,999,999 claims daily

F: Line Number

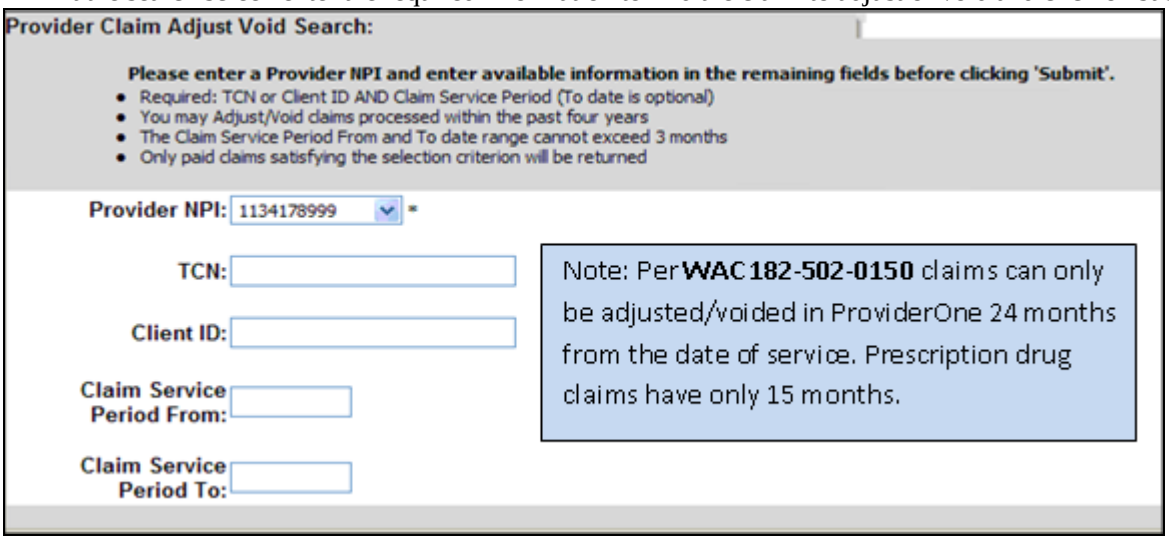
- The claim level number will be 000
- Each claim line also has a TCN number. The line number will start with 001 for each new claim line. (HIPAA Transactions can have up to 999 lines)

Adjust or Void a Paid Claim

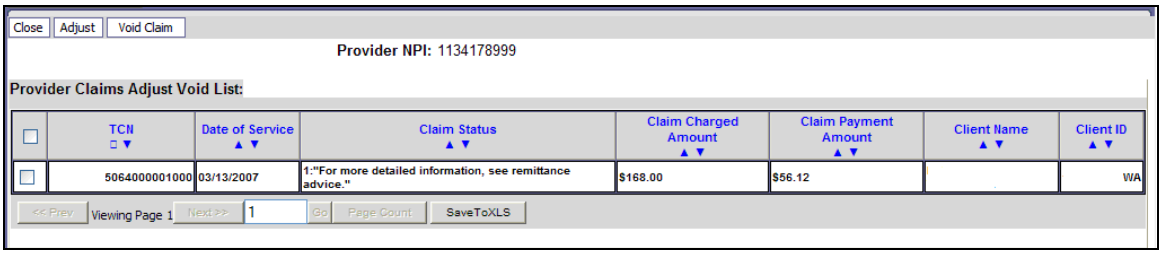
Select "Claim Adjustment/Void" from the Provider Portal.



At the search screen enter the required information to find the claim to adjust or void and click on submit.

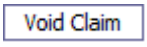


The system will then display claim(s) based on the search criteria.



Click on the box next to the TCN, then click the adjust Adjust button in the upper left hand corner. The claim will then be displayed in the DDE screen with the values of the selected claim filled in the data fields. Make the necessary changes then resubmit the adjustment request to Medical Assistance for processing. The system will go thru the same final steps of a claim submission asking if back up is being sent, etc.

Remember to click the "OK" button on the **Submitted Claim Details** screen to finish sending in the resubmitted claim! A different TCN will be assigned to the claim after it is resubmitted.

If the claim is being voided click on the 

button in the upper left hand corner. The claim data will be displayed in the DDE screen but all the values will be grayed out and cannot be changed. Simply click the submit button and the void will be sent to Medical Assistance for processing and will show up as a credit on the RA.

Paper Adjustment/Void

- Enter the Transaction Control Number (TCN) found on the Remittance Advice (RA) in the appropriate box on the claim form. The adjustment/voids are done on the same claim form used for the initial billing. Complete the form with all the necessary claim information. See directions in the table below on how to adjust and void each claim type.

	Adjust/Replace a Paid Claim	**Void/Cancel a Paid Claim**
Professional Claims	Adjust a Professional claim (CMS-1500) by entering the claim frequency type code 7 then the TCN in field #22 (Medicaid Resubmission Code). Example: 22. Medicaid Resubmission Code: 7 | Original Ref No.: 300629600000340000	Void a Professional claim (CMS-1500) by entering the claim frequency type code 8 then the TCN in field #22 (Medicaid Resubmission Code). Example: 22. Medicaid Resubmission Code: 8 | Original Ref No.: 300629600000340000
Institutional Claims	To adjust or replace an institutional claim, submit 7 as the last digit of the Type of Bill. Put the TCN of the claim to adjust in form locator 64. Example 7-300629600000340000	To void or cancel an institutional claim, submit 8 as the last digit of the Type of Bill. Put the TCN of the claim to adjust in form locator 64. Example 8-300629600000340000
Dental Claims	Adjust a dental claim by entering the claim frequency type code 7 then the TCN in field 35 (Remarks) Example: 7-300629600000340000	Void a dental claim by entering the claim frequency type code 8 then the TCN in field 35 (Remarks) Example: 8-300629600000340000

- Complete adjustments on the applicable claim form (CMS 1500. UB04 or ADA2006).
  - Use only one applicable claim form per claim.
  - Submit multiple line corrections to a single claim on one applicable claim form.
  - See special instructions on the following page if adjusting an overpayment.
  - Adjust the most recent claim in "paid status".

- Use the same process for Adjusting/Voiding a Medicare Crossover claim.

- Attach proper documentation to the adjustment request
  - Include operative reports (if needed for payment)
  - Insurance EOBs.
  - Medicare EOB
  - Any invoice or other documentation.

- Send the paper adjustment to the Agency
  - Mail to The Health Care Authority
    Division of Medical Benefits and Care
    PO BOX 9248
    Olympia, WA 98507-9248

- ProviderOne will locate the claim to adjust. The entire original claim will be credited (represented as minus amounts on the RA transaction) back to the Agency to allow the adjusted claim to pay correctly (represented as replacement amounts on the RA transaction). The Adjustment Reason Code 129 will appear in that column on the RA associated with the credit transaction.

- If a provider is voiding/canceling an overpayment claim, submit a void claim request
  - The Agency will recoup the claim and deduct the excess amount from a future remittance check(s) until the overpayment is satisfied;

OR

- Issue a refund check payable to the Health Care Authority
  - Attach a copy of the RA showing the paid claim and include a brief explanation for the refund.
- Mail to The Health Care Authority
  - Finance Division
    PO BOX 9501
    Olympia, WA 98507-9501

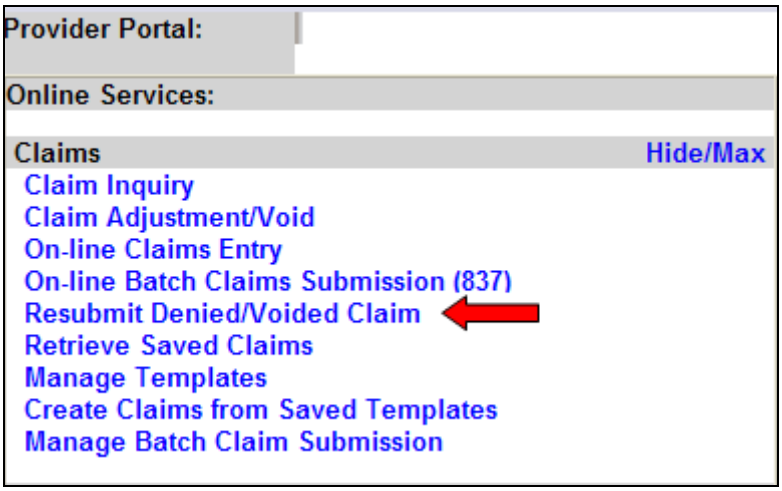
The billing time periods do not apply to overpayments that the provider must refund to the Agency. After the allotted time periods, a provider may not refund overpayments to the Agency by claim adjustment. The provider must refund overpayments to the Agency by a negotiable financial instrument such as a bank check. [Refer to WAC 182-502-0150 (8)]

Note: The adjusted/replaced claim will appear on the Remittance Advice (RA) in the adjustment claim section as two transactions, 1) the original claim and 2) the replacement claim. The claim paid amount would be adjusted accordingly based on the adjustment request and the adjusted amount would be reflected in the total payment. See section Reconcile the RA for a complete RA explanation.

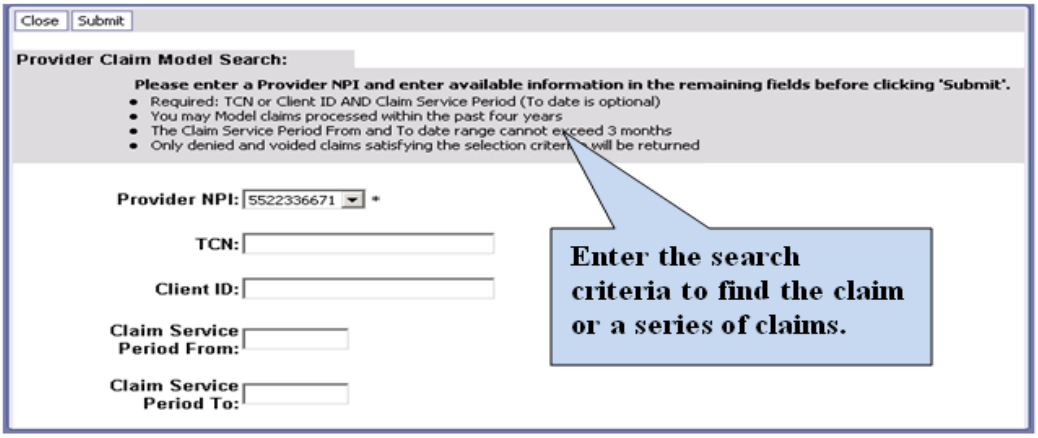
Note: When a claim is voided the Agency will recover the amount originally paid from the next total payment and the voided claim will appear on the RA as only one transaction (credit).

Resubmit a Denied Claim

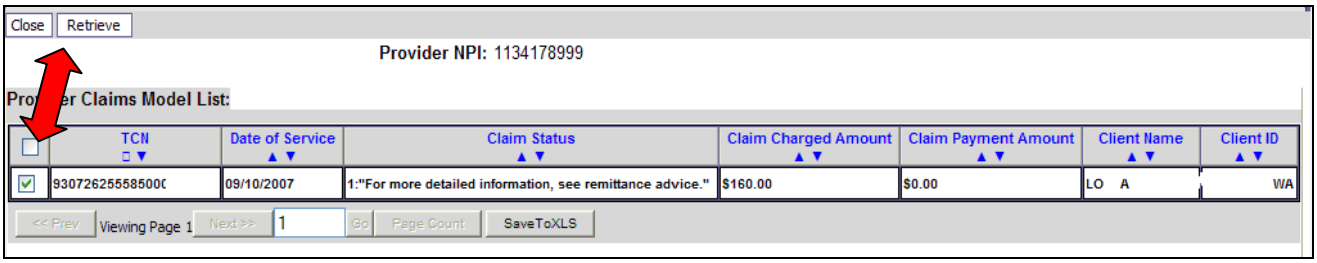
Select "Resubmit Denied/Voided Claim" from the Provide Portal main menu.



Search for the claim by entering the appropriate information then click the "submit" button



ProviderOne will display the claim list screen. Click on the box next to the TCN of the claim to be resubmitted then click the "Retrieve" button in the upper left hand corner. The claim will be displayed in the DDE screen with the values of the selected claim in the fields and will indicate the type of claim.



Make any necessary changes to the claim using the same procedure as describe above in adjusting a claim section. When the changes are done submit the claim to Medical Assistance for processing. The system will go thru the same final steps of a claim submission asking if back up is being sent, etc.

Remember to click the "OK" button on the **Submitted Claim Details** screen to finish sending in the resubmitted claim! A different TCN will be assigned to the claim after it is resubmitted.

Pitfalls

- **Failing to include the TCN in the applicable field on the paper claim form adjustment request. This will cause the adjustment claim to be denied as a duplicate claim.**
- **Failing to indicate the TCN on the paper claim form adjustment. This will cause Medical Assistance to be unable to complete the request.**
- **Adjusting the wrong claim or claim line. This could result in unexpected results with the claim and payment.**
- **Failing to click the "OK" button on the Submitted Claim Details screen will result in the claim not being sent to Medical Assistance.**

Key Step
7

7. Creating a Template Claim

Why

ProviderOne allows a provider to create and save a template of a claim for services they may be billing for a client on a weekly, bi-weekly, or monthly basis. When creating a DDE template, the provider can add as much claim information to the template as they need or want however the system does require a minimum of information to be able to save the template. The minimum required information is:

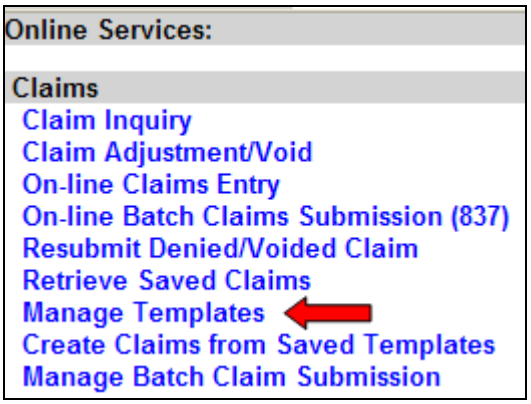
- A Template Name
- Answer the questions on the DDE screen
- If a closed data field is opened then additional information may be required

Once saved a template can be used to submit a claim and the template can be used over and over again to create claims. The template can be edited and resaved or deleted if no longer useful. Many templates can be created and saved. The next chapter is about submitting a template claim.

How

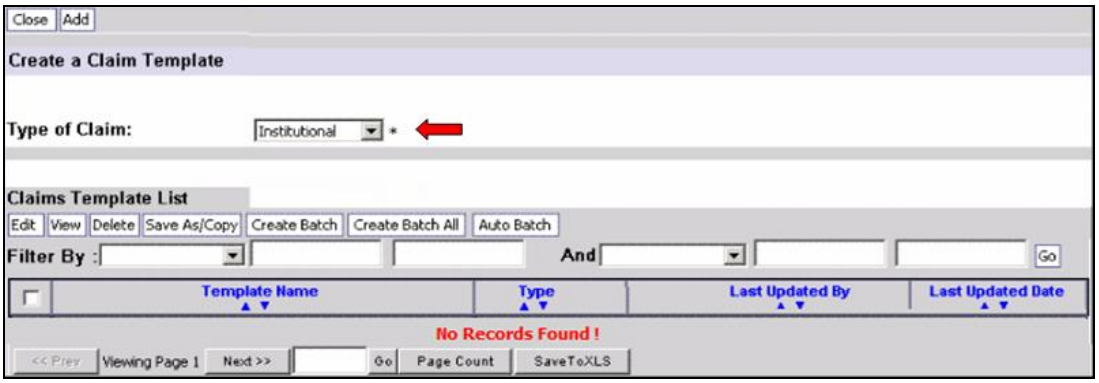
Create a template (s) using the DDE screens.

- Log into ProviderOne with the **EXT Provider Claims Submitter** or EXT **Provider Super User** profile.
- From the Provider Portal, click on the **Manage Templates** hyperlink



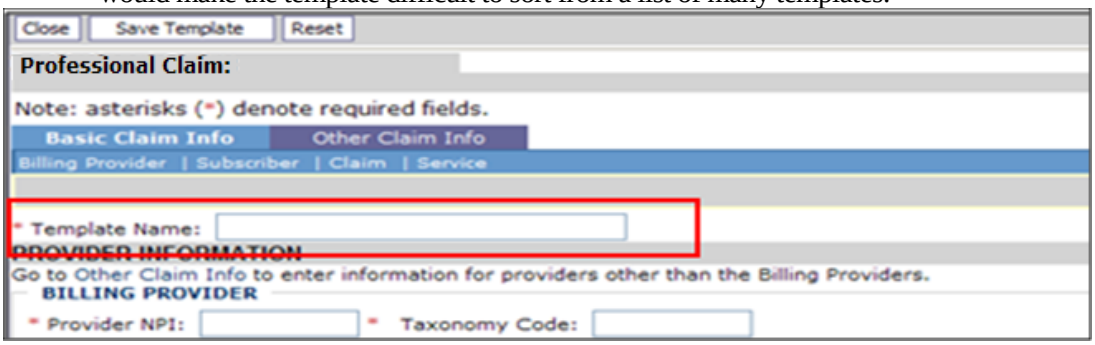
At the **Create a Claim Template** screen providers can perform many actions with a template.

Create a Template



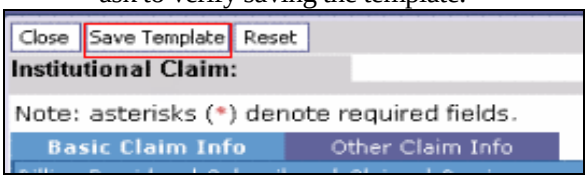
- First, start building a template by choosing which type of template is desired then click on the **Add** button.

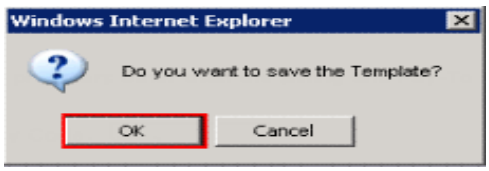
- Pick a name for the template. Use a name that describes a service or use the client's name. It is best not to use a template name that uses alpha/numeric characters that are common to all templates which would make the template difficult to sort from a list of many templates.



- Fill in as many data fields as possible. If the template is for a client that receives specific services monthly then fill in all fields except the dates of service. If the template is service specific then fill in all the service information and leave off the client information and dates of service.

- Once the template is complete and ready to save click on the **Save Template** button. The system will ask to verify saving the template.



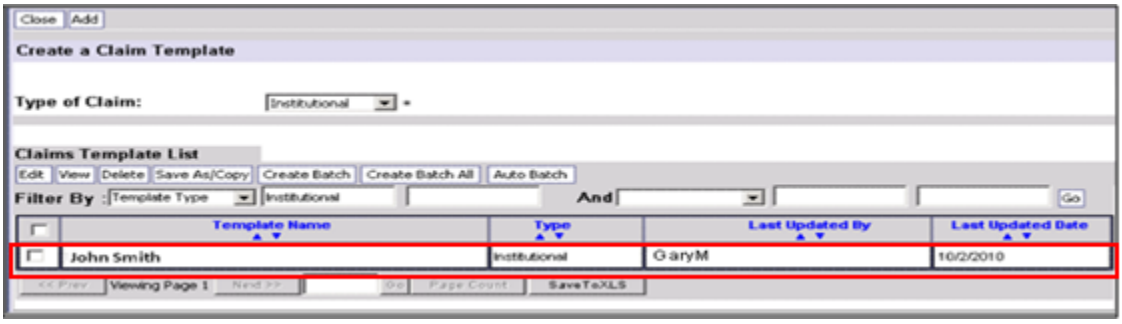


Note: If ProviderOne returns the error message "**Warning: Template Name already exits, please enter a unique name**" could be caused by one of two things:

- A template has been created with this name in the providers domain; or
- ProviderOne found the template name already existed in history.

If the template is truly a new one for the domain, simply add a number like 1 or 2 to the end of the template name and try to save again.

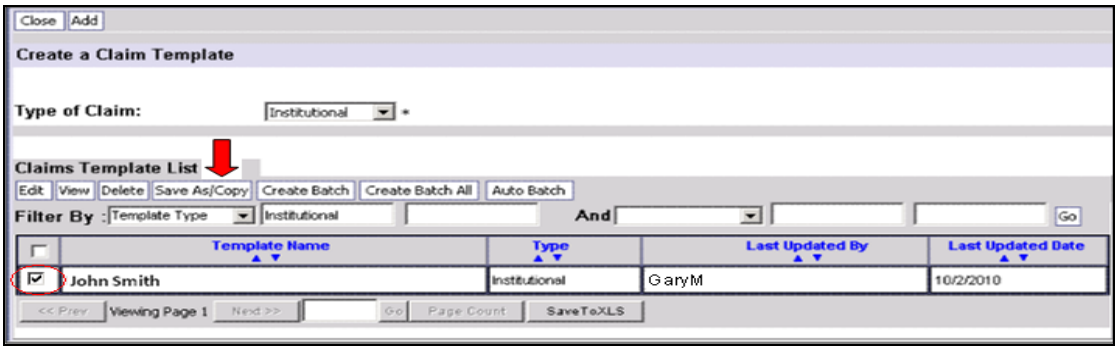
- After clicking the OK button, ProviderOne returns to the Claim Template screen adding the template to the list.



- Add as many templates as needed.
  - Create new ones using the above method or;
  - Copy the saved template then edit it

Copy a Template

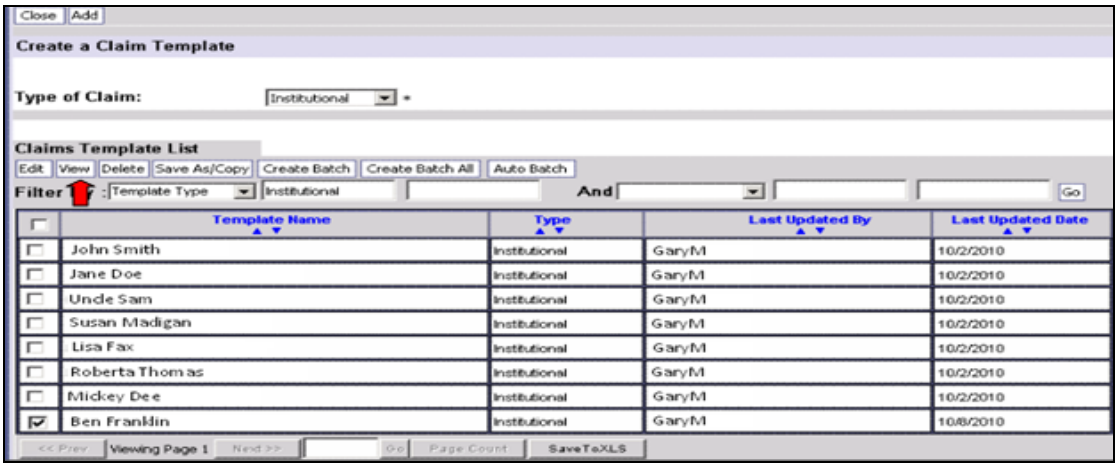
- To copy a template, click on the box next to the template name



- Then click on the **Save As/Copy** button
- The system now displays the DDE screen with the template information except the template name. Name this template and change any data as needed then save the template. Build as many templates as required using this method.

View a Template

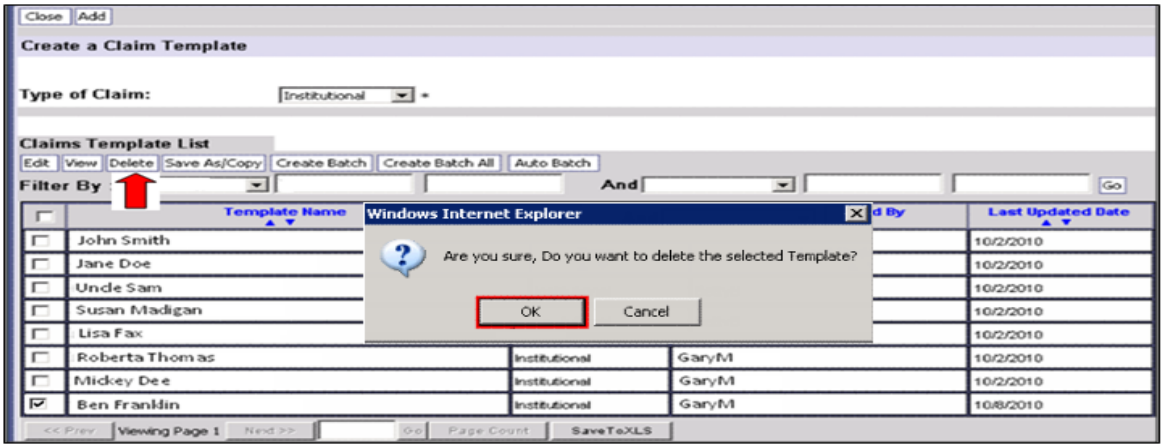
- To view a template, click on the box next to the template name



- Then click on the **View** button
- The system now displays the DDE screen with the template information and all the template data is grayed and cannot be edited.

Delete a Template

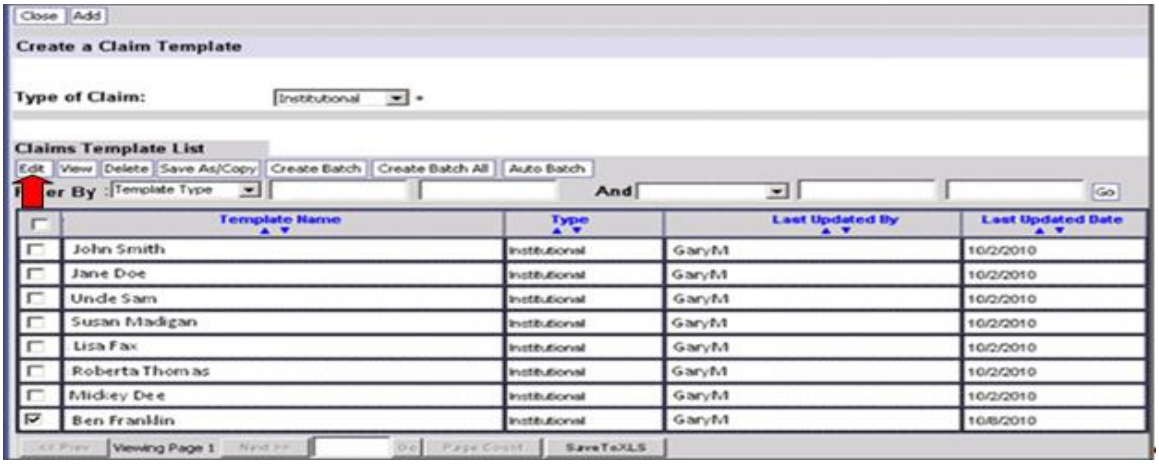
- To delete a template, click on the ☑ box next to the template name



- Then click on the **Delete** template button
- Clicking on the OK button deletes the template

Edit a Template

- To edit a template, click on the ☑ box next to the template name



- Then click on the **Edit** button
- The system now displays the DDE screen with the template information available to edit and be changed or updated as needed.

Note: When building and saving a template ProviderOne will ignore some of the system rules i.e. not all asterisk (required) fields need data entered.

Pitfalls

- **Choosing the wrong profile after logging into ProviderOne.**
- **Choosing the wrong claim type for the template.**
- **Using common starting characters in naming the template. Makes it difficult to sort to find a template on a large list.**

Key Step
8

8. Submitting a Template Claim or a Batch of Template Claims

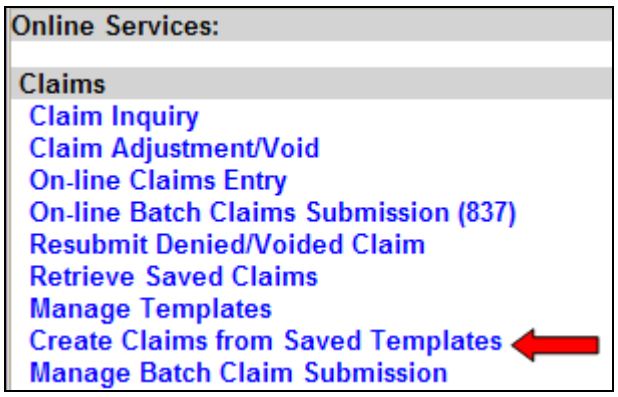
Why

Providers that bill reoccurring services for a client or clients may want to use a claim template to create and submit those claims.
ProviderOne also allows providers to build batches of templates into a batch of claims instead of submitting a single claim template one at a time.
ProviderOne only allows institutional providers to use the **Auto Batch Button** to build claim templates into a batch of claims.

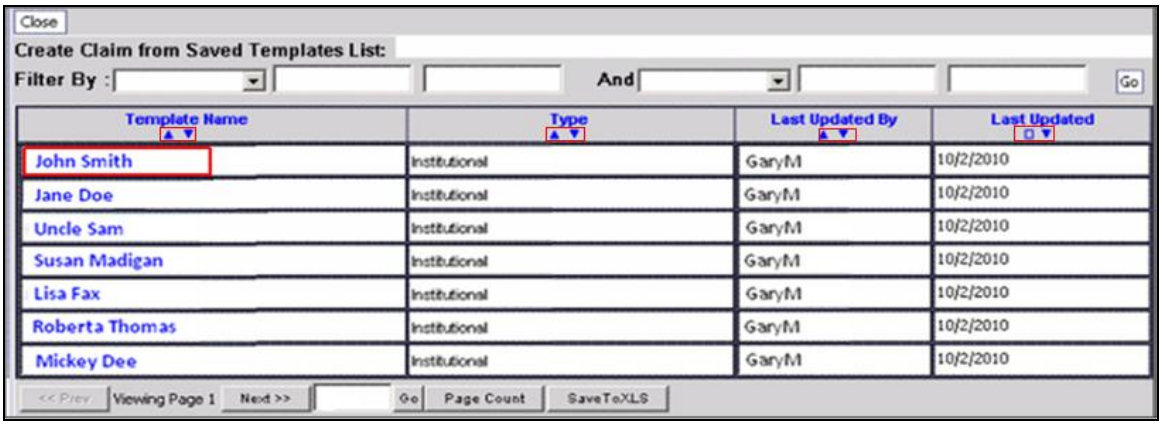
How

Submit a Single Claim from a Template

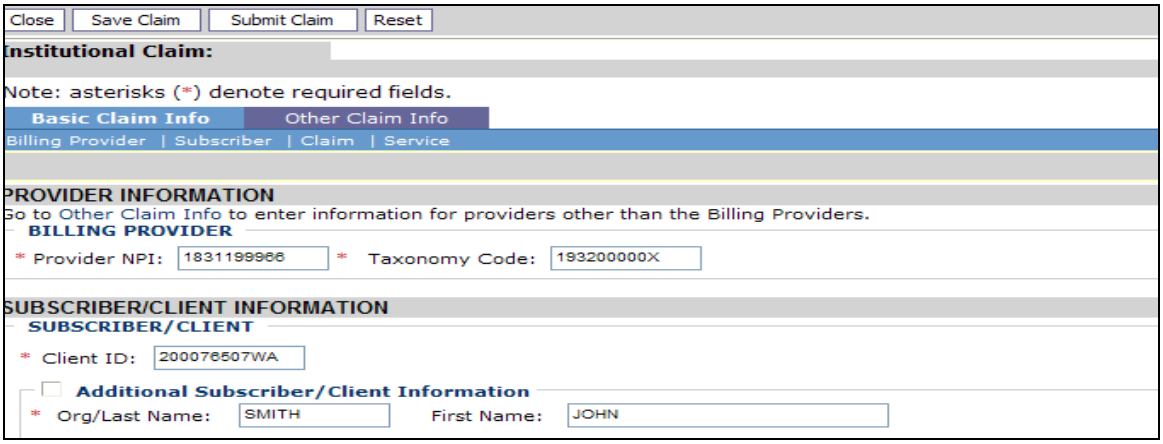
- Log into ProviderOne with the **EXT Provider Claims Submitter** or **EXT Provider Super User** profile.
- From the Provider Portal, click on the **Manage Templates** hyperlink



- ProviderOne should display the **Create Claim from Saved Templates List** screen.



- The list of templates can be sorted if it is huge by a couple of methods:
  - Use the Filter By boxes to find a specific template or;
  - Use the sort tool (little diamonds) under each column title which sort from top to bottom or bottom to top.
- Click on the template name hyperlink which loads the template in the DDE screen.



- At the DDE screen finish filling in the claim data.
- Once all the data is entered the claim can be saved or submitted to ProviderOne.
- If submitting the claim, ProviderOne will ask if back up is being sent. If sending back up complete that process.
- Click on the OK button to submit the claim.
- Go back to the **Create Claim from Saved Templates List** screen if another claim needs to be submitted using a template.

Submit a Batch of Template Claims

ProviderOne has the ability to identify and gather a group of claim templates together to create a batch of templates for submission into the system as a batch of claims. This process has these basic requirements:

- All claim types must be the same in the batch(i.e. professional, dental, or institutional)
- All batch templates will be for the same date of service (or date span)
- The billed amount could be the same on each claim template (based on the date(s) of service)
- Each claim template units will be the same (calculated based on the date(s) of service)

A detailed explanation of the process is beyond the capacity of this publication however the **ProviderOne Managing Claims** system manual has a complete overview of the process. **Nursing Home providers** submitting Institutional claims have a detailed webinar and presentation slide show demonstrating the complete process. Other provider types wanting to use the process would follow the same steps however they may be using a different claim form.
The basic process outline includes:

- Log into ProviderOne and go to **Manage Templates**
- At the **Claims Template List** screen there are 3 options to create a batch of claim templates:
  - Create Batch
  - Create Batch All
  - Auto Batch
- At the **Batch Claim Attributes** screen assign the From-To dates of service then build the batch
- Each batch is assigned a batch number
- Now at the portal page switch to the **Manage Batch Claim Submission** hyperlink
- At the **Batch Claim Submission Status List** page check the status of a batch. Status can be:
  - Waiting
  - In Process
  - Failed in Validation
  - Passed Validation
  - Submitted for Claims Loading
- Only template batches that have **Passed Validation** can be submitted as claims
- Submitted **Passed Validation** batches are now in **Submitted for Claims Loading** status. Claims are assigned a TCN and start processing in ProviderOne. This template batch is then auto purged from the list page.

Pitfalls

- **Forgetting to change a data element that needed changing on a template. Could result in a denied claim or an overpaid claim.**
- **Trying to submit a batch of templates that are different claim types.**
- **Not keeping track of the batch number for specific template batch service.**
- **Trying to submit a batch of templates that have not passed validation.**